



Digitized by the Internet Archive
in 2016

January 1981

Journal of
the Medical
Society of

New Jersey

Scoliosis Bracing

R. Fernand, M.D., et al.

Ultrasonic Imaging of
Cervical Carotid Arteries

*R. W. Hobson, II, M.D.,
et al.*

Immunotherapy:
Unfulfilled Promise

R. S. Greco, M.D.

Pregnancies Complicated
by Kyphoscoliosis

*M. Kreitzer, M.D.
M. Gregory, M.D.*

Complete Table of
Contents on page 4

LIBRARY
U.C. SAN FRANCISCO

JAN 27 1981

Acquisitions Division
Univ. of Calif., San Francisco
San Francisco, Calif. 94143 S

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

***Check this list
against your
coverages***

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$5000 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____



Fair Oaks: A Private Psychiatric Hospital

Services provided by Fair Oaks Hospital are organized through six separate and self-contained specialty units. Each of the programs is directed by a senior psychiatrist who is a full time inpatient specialist. The psychiatrist coordinates the efforts of a staff selected for training and experience specific to the task of the unit.

NEUROPSYCHIATRIC EVALUATION PROGRAM

This program is designed to provide, within one to two weeks, a comprehensive neuropsychiatric assessment that results in specific and individualized treatment recommendations for the patient. Neurochemical, psychodiagnostic and neurological testing is combined with a family and psychosocial assessment as well as extensive clinical diagnostic interviewing based on the most modern methods of classifying psychiatric disorder. The results of this evaluation, including treatment recommendations, are provided to the referring clinician and, if the patient remains in the hospital for further treatment, to the Fair Oaks Hospital Treatment Program.

DEPRESSION EVALUATION PROGRAM

This program is designed for the comprehensive evaluation of depression and affective disorder. Headed by an authority in this area of medicine, the program utilizes the neuropsychiatric evaluation format with a special emphasis on new and reliable diagnostic biological indices of depression, such as dexamethasone suppression testing. Fair Oaks is the only specialty hospital in New Jersey to offer this innovative and comprehensive program of interview and neurobiological testing procedures.

ADOLESCENT TREATMENT PROGRAM

Fair Oaks Hospital offers a specialized evaluation and treatment program for adolescents. This program has been granted approval as an adolescent treatment program by the Joint Commission on Accreditation of Hospitals. Along with child psychiatrists, psychologists, social workers, nursing staff and recreational and creative therapists, all specially trained to work with adolescents, the program includes a formal educational experience, so that adolescents may continue their studies during treatment.

ALCOHOL AND SEDATIVE DEPENDENCE TREATMENT PROGRAM

The One Day At A Time unit offers treatment to persons dependent on alcohol or sedatives by means of a twenty-eight day program of physical stabilization, counseling and introduction to continuing supports such as Alcoholics Anonymous.

ADULT TREATMENT PROGRAM

The adult program is designed to build upon the evaluation and recommendations generated by the Neuropsychiatric Evaluation Program. Treatment of patients is continued with careful observation and monitoring of patient progress, including newly developed laboratory techniques for therapeutic drug monitoring. Interpersonal and psychosocial problems are explored and treated through group, family and individual psychotherapy. Families are seen individually and in groups in order to deal with family issues and in order to help the family keep abreast of patient progress. Furthermore, trained therapists coordinate an active program of recreational, vocational and creative therapies.

DRUG ABUSE TREATMENT PROGRAM

Utilizing new treatments developed by our physician researchers at Yale and Fair Oaks, patients are offered a treatment program that detoxifies and rehabilitates poly-drug abusers and opiate and methadone addicts. This program has developed and implemented new nonopiate treatments for addicts that make drug and opiate-free living a reality for motivated patients. Employing special tests for the biological monitoring of patient progress, specially trained staff provides treatment and works closely with family and referral source to prevent relapse.

For further information, write or call the Admissions Coordinator

Fair Oaks HOSPITAL

19 Prospect Street
Summit, New Jersey 07901
(201) 277-2300

Call Toll-Free 24 Hours a Day
In New Jersey Outside New Jersey
(800) 672-1907 (800) 526-4494

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



Officers and Trustees

PRESIDENT

Augustus L. Baker, Jr., M.D. (Morris) Dover

PRESIDENT-ELECT

Armando F. Goracci, M.D. (Gloucester) Woodbury

FIRST VICE-PRESIDENT

Howard D. Slobodien, M.D. (Middlesex) Perth Amboy

SECOND VICE-PRESIDENT

Alexander D. Kovacs, M.D. (Union) Scotch Plains

IMMEDIATE PAST-PRESIDENT

Alfred A. Alessi, M.D. (Bergen) Hackensack

SECRETARY

Arthur Bernstein, M.D. (Essex) East Orange

TREASURER

Rudolph C. Gering, M.D. (Mercer) Pennington

Trustees

CHAIRMAN

William Greifinger, M.D. (1981) (Essex) Belleville

Meyer L. Abrams, M.D. (1982) (Burlington) Cherry Hill

Frank Campo, M.D. (1981) (Mercer) Trenton

Douglas M. Costabile, M.D. (1981) (Union) Murray Hill

John J. Crosby, Jr., M.D. (1981) (Hudson) Jersey City

Anthony P. DeSpirito, M.D. (1982) (Monmouth) Neptune City

Ralph J. Fioretti, M.D. (1983) (Bergen) Rochelle Park

Palma E. Formica, M.D. (1981) (Middlesex) Old Bridge

Sherman Garrison, M.D. (1983) (Cumberland) Bridgeton

John P. Kengeter, M.D. (1981) (Ocean) Toms River

Richard E. Lang, M.D. (1981) (Passaic) Passaic

Myles C. Morrison, Jr., M.D. (1982) (Morris) Morristown

John A. Surmonte, M.D. (1981) (Salem) Penns Grove

Frank Y. Watson, M.D. (1983) (Essex) Montclair

Councillors

FIRST DISTRICT

(Essex, Morris, Union, and Warren Counties)

Merton L. Griswold, Jr., M.D. (1981) Plainfield

SECOND DISTRICT

(Bergen, Hudson, Passaic, and Sussex Counties)

Robert A. Weinstein, M.D. (1983) Newton

THIRD DISTRICT

(Hunterdon, Mercer, Middlesex, and Somerset Counties)

Albert F. Moriconi, M.D. (1982) Trenton

FOURTH DISTRICT

(Burlington, Camden, Monmouth, and Ocean Counties)

Frederick W. Durham, M.D. (1981) Haddonfield

FIFTH DISTRICT

(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)

Ronald M. Fisher, M.D. (1983) Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982) Hackensack

William J. D'Elia, M.D. (1981) Spring Lake

Frederick W. Durham (1982) Haddonfield

Karl T. Franzoni, M.D. (1982) Trenton

John S. Madara, M.D. (1982) Salem

Henry J. Mineur, M.D. (1982) Cranford

January 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*

Julio C. del Castillo, M.D.

John F. Marshall, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.

Harold Arlen, M.D.

Alfonse Cinotti, M.D.

Stuart D. Cook, M.D.

Robert Dodelson, M.D.

Wm. A. Dwyer, Jr., M.D.

Norman H. Ertel, M.D.

Arthur Goldfarb, M.D.

Robert A. Goldstone, M.D.

Murray Kahn, M.D.

Monroe S. Karetzky, M.D.

Avrum L. Katcher, M.D.

Sidney Ketyer, M.D.

Bernard J. Koven, M.D.

Joel D. Levinson, M.D.

Henry R. Liss, M.D.

Hugh F. Luddecke, M.D.

Murray Nussbaum, M.D.

Christopher M. Papa, M.D.

Victor Parsonnet, M.D.

Bernard D. Pinck, M.D.

Irwin Pollack, M.D.

Edwin L. Rothfeld, M.D.

Benjamin Rush, M.D.

Morris H. Saffron, M.D.

Mark M. Singer, M.D.

Leon G. Smith, M.D.

Sheldon D. Solomon, M.D.

Lloyd N. Spindell, M.D.

A. Arthur Sugerman, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 920. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

TAGAMET®

BRAND OF CIMETIDINE

How Supplied:

- Pale green 200 mg. tablets in bottles of 100;
pale green 300 mg. tablets in bottles of 100 and Single
Unit Packages of 100 (intended for institutional use only).
- Liquid, 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles.
- Injection, 300 mg./2 ml., in single-dose vials and in
8 ml. multiple-dose vials, both in packages of 10.

SK&F LAB CO.
a SmithKline company

SK&F Lab Co., Carolina, P.R. 00630

© SK&F Lab Co., 1980



Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

13 **PROFESSIONAL LIABILITY COMMENTARY**

EDITORIALS

- 17 Caution: I Brake for Unicorns
18 The Ventnor Foundation

21 **JEMPAC REPORTORIAL**

ORIGINAL ARTICLES

- 22 Modern Concepts of Scoliosis Bracing
R. Fernand, M.D.; A. E. Stefanelli, M.D.; B. Ernst, C.P., Newark
26 Ultrasonic Imaging of the Cervical Carotid Arteries
R. W. Hobson, II, M.D., Newark; S. M. Berry, M.Sc.; C. E. Marsters, P.A., East Orange;
A. S. Katocs, Jr., Ph.D.; J. P. Savitsky, M.D., Pearl River, NY
32 Immunotherapy: The Unfulfilled Promise
Ralph S. Greco, M.D., Piscataway

CASE REPORTS

- 36 Maternal Mortality in Pregnancies Complicated by Kyphoscoliosis
Michael Kreitzer, M.D.; Margaret Gregory, M.D., Trenton
39 Transurethral Resection in a Two-Year-Old Boy
Peter C. Boorjian, M.D., Montclair
41 Multicentric Endobronchial Granular Cell Myoblastoma
K. Davessar, M.D.; W. Farmer, M.D.; S. Becker, M.D., Freehold

SPECIAL ARTICLE

- 44 History of My Stroke
Gerald E. Muehsam, M.D., Short Hills

THE ELECTROCARDIOGRAM

- 48 Double Tachycardias
Edwin L. Rothfeld, M.D., Newark

CLINICAL NOTES

- 50 Duodenal Hematoma
Donald Rothman, M.D., Red Bank
51 Pediculosis Upsurge
Leon G. Smith, M.D., Newark

52 **THERAPEUTIC DRUG INFORMATION**

YOUR CONGRESSMAN SPEAKS

- 54 The DMSO Controversy—A Congressional Perspective
The Honorable Robert A. Roe, Washington, D.C.

56 **ANNUAL MEETING HOUSING APPLICATION**

DOCTORS' NOTEBOOK

- 58 Trustees' Minutes: November 16, 1980
59 Report from the Foundation
60 CMDNJ Notes
61 Physicians Seeking Location New Jersey

64 **LETTERS TO THE JOURNAL**

65 **CME CALENDAR**

70 **OBITUARIES**

72 **BOOK REVIEWS**

Cover

The cover is a charcoal drawing by Elizabeth Ruggles. Miss Ruggles is a well-known teacher and painter in the area and formerly was staff artist for the New Jersey State Department of Health.

Fifty Percent of our Traumatically Injured Patients are the Victims of Motor Vehicle Accidents.

**Drive
Patiently
for a
Happier
New Year.**



New Jersey Rehabilitation Hospital

Owned and operated by Moderncave Centers of America, Inc.

240 Central Avenue East Orange, NJ 07018 • 201-673-1860

Bertrand J. Bensam, MD, Medical Director • Stan Shepard, Administrator


Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities
and the American Board for Certification in Orthotics and Prosthetics, Inc.



**Acute pain
is no laughing matter.**

The first prescription for the first days of acute pain

Empirin® \bar{c} Codeine #3


Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg. (Warning — may be habit-forming). 

**For the millions of patients who need the potency
of aspirin and codeine for their acute pain.**

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin \bar{c} Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin \bar{c} Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin \bar{c} Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming) 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSEAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

The Journal, the Medical Society of New Jersey

Information for Readers and Contributors

The Journal is the official organ of the Medical Society of New Jersey. It is published monthly under the direction of the Committee on Publication and is released the first week of the month. A copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. Each issue contains material of special interest to the members, including actions and opinions of the Board of Trustees. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles, case reports, review articles, clinical notes, and special articles*. Contributors must understand that material submitted here is for exclusive publication in *The Journal*. The Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*; such permission must be requested by the author. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Accuracy, honesty, and comprehensibility are primary requisites. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by *all* authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SCIENTIFIC ARTICLES

Scientific articles should be based on personal studies and observations by the authors. The content may include research data, original concepts relative to epidemiology of disease, treatment methodology, educational theory and practice, and so on. Papers of this description may be technical or clinical in nature, but relevance to our readership must be considered.

CASE REPORTS

One or more interesting or unusual clinical case experiences may be submitted for consideration. The case(s) should have unique features worthy of the attention of our readers. Case reports should be short, and the discussion should deal with the condition described. References must be limited; a case report is *not* a review of the world's literature.

CLINICAL NOTES

The Editor will consider brief items of interest to clinicians. Clinical notes may include some aspect of a case experience or deal with a new observation or technique. Clinical notes do not require the benefit of intensive research nor references, but should be succinct, didactic presentations.

SPECIAL ARTICLES

These will include scholarly evaluations, essays, policy and position papers, medical history, and reviews of non-scientific subjects.

REVIEW ARTICLES

Authors may submit comprehensive reviews on topics of interest, but such reviews must be careful critiques based on personal reading of reference articles. Authors of review articles are advised to discuss in advance with the Editor the potential for publication of a particular topic.

EDITORIALS

The Editor and Associate Editors prepare editorials on timely and relevant subjects for *The Journal*. Guest contributors will be invited to prepare editorials on specific topics. Editorials may be provocative, but will remain within the bounds of good taste and legal restrictions. Special editorials may pay tribute to past or present members of the Society who have attained high office or made important contributions worthy of special recognition. Editorials may comment on original articles. All editorials are the responsibility of the authors and not of the Medical Society of New Jersey.

COMMENTARIES

The commentary is a long editorial which deals with a particular topic in greater detail. Commentaries will be written by the editorial staff or by invited contributors.

NEW JERSEY DOCTORS' NOTEBOOK

This department contains organizational and administrative items from the Medical Society. It also contains reports and information worthy of special attention to New Jersey physicians. Material may emanate from within the Society, from state or federal government agencies or elsewhere. Actions of the Board of Trustees will be recorded here. Names, addresses, specialties, and qualifications will be published regularly for physicians seeking to locate in our state—as a service to them and to physicians and hospitals looking for practitioners as associates or employees.

LETTERS

Letters to the Editor will be published. Here again, the bounds of good taste and legal considerations dictate a measure of restraint, although correspondents are free to express their opinions.

BOOK REVIEWS

Books of interest to physicians or their patients will be reviewed. The Editor will request a member of the Society or

another qualified person to review each book and to prepare a succinct comment for publication in *The Journal* and for the benefit of the publisher.

CME CALENDAR

The Journal publishes a calendar of medical events in New Jersey in a timely fashion to assist physicians in their continuing medical education. The material is compiled by MSNJ's Committee on Medical Education, the Academy of Medicine of New Jersey, the New Jersey Chapter of the Academy of Family Physicians, and the office of Continuing Education of the College of Medicine and Dentistry of New Jersey.

ADVERTISEMENTS

The Journal accepts advertising material of interest to physicians from national and local sources. Each item is scrutinized for accuracy and fairness, but *The Journal* does not "warrant the safety or efficacy of products so advertised."

OBITUARIES

Notices of the death of members of the Medical Society of New Jersey are published in *The Journal* as soon as possible after receipt of information. These will be factual rather than personal since they are prepared by the editorial staff.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editor. Authors must understand that the essential content of the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data, special photographs, and so on).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality, photographed and submitted as black-and-white glossy prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author. **Title Page**—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article. Because of its brevity every word and idea counts. The abstract is a summary of the summary.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

Authors are responsible for the accuracy of references. The reference list should not exceed 35 citations except in review articles. Where the number of references is excessive, *The Journal* may ask the author to bear the cost of the extra pages.

PUBLICATION POLICY

The receipt of each manuscript will be acknowledged immediately and the manuscript delivered to the Editor who will begin the review process. *The Journal* maintains a Manuscript Review Board, appointed by the Board of Trustees. The members are acknowledged authorities selected from the membership of MSNJ. The Editor sends each manuscript to one or more reviewers who carefully scrutinize the material and render an opinion to the Editor as to the potential for publication. The final decision is reserved for the Editor. Where necessary, qualified ad hoc reviewers are consulted. The Editor notifies the authors of his decision. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. After acceptance, galley proofs will be prepared and submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar should not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

CHANGE OF ADDRESS

Notice of change of address should be sent promptly to the Medical Society of New Jersey, 2 Princess Road, Lawrenceville, New Jersey 08648.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Road, Lawrenceville, New Jersey 08648.

The 3RD ANNUAL Atlantic City Boat Show '81

JANUARY 31 - FEBRUARY 8, 1981

**HOURS: Sat. & Sun. 11am - 10pm
Mon. - Fri. 4pm - 10pm**



- More than 10 million dollars worth of boats and accessories
- Motor yachts to 48 feet, Sailing yachts to 50 feet,
Sport fishermen to 44 feet, Trawlers to 46 feet

Expanded to 9 Big Days!

**Convention Hall
Atlantic City, N.J.**

Produced by: Creative Mall Promotions, Inc.

For Step-1 diuretic therapy that

start
with...



81%
responded
with a decrease
in diastolic pressure
of 10 mm Hg or more

69%
were normalized
with a decrease
in diastolic pressure
to 90 mm Hg or less

• HIGH SUCCESS RATES

A series of well-controlled studies was undertaken on patients with mild to moderate hypertension (diastolic blood pressure greater than 90 mm Hg, but less than 120 mm Hg). These patients were treated with Zaroxolyn alone for 6 months.¹⁻⁶

Long-acting
Zaroxolyn®...As much therapy as many of
(metolazone) Pennwalt

improves the bottom line...

stay
with

Long-acting
Zaroxolyn[®]
(metolazone) Pennwalt

2½ mg, 5 mg, 10 mg tablets

- NO TOLERANCE TO THE ANTIHYPERTENSIVE EFFECT NOTED IN LONG-TERM USE^{1,4,5}
- WELL-TOLERATED ANTIHYPERTENSIVE THERAPY¹... ONCE DAILY TO ENCOURAGE PATIENT COMPLIANCE

your hypertensive patients may ever need

Please see following page for prescribing information.

Long-acting
Zaroxolyn[®]
(metolazone) Pennwalt

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma, allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients, dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of child-bearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg, edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Van Hoose MC, Cutler RE: Antihypertensive efficacy of metolazone (Zaroxolyn) alone and combined with reserpine in treatment of essential hypertension. *Curr Ther Res* 20:266-276, 1976. 3. Cangiano JL, Campos JA, Trevino A IV, et al: The effects of metolazone in the long-term treatment of essential hypertension. *Curr Ther Res* 16:778-785, 1974. 4. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Curr Ther Res* 20:745-750, 1976. 5. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18:527-533, 1975. 6. Materson BJ, Oster JR, Perez-Stable EC: Antihypertensive effects of metolazone (Zaroxolyn). *Curr Ther Res* 16:890-896, 1974.

R DIVISION
PENNWALT
ROCHESTER, NEW YORK 14625

A-254

You're important! And that's how we treat you!

Tell us what you want in your car...we'll get it.

Tell us whether you want to buy or lease...we'll arrange it.

Tell us what you consider a fair price...we'll work it out.

We'll do everything in our power to keep you happy. And that even means a free loaner car when you need it.

Because you're important!

Call Allan Mullens at 748-8200, and be treated that way!



425 Bloomfield Ave • Bloomfield, N.J.
201 748 8200 • Exit 148 Garden State Pkwy
New and used BMW cars and care • Leasing

Featuring: Cause of Action Based on Lack of Informed Consent

MEDICO-LEGAL VIDEO TAPES READY FOR DISTRIBUTION

The Department of Professional Liability Control has produced a series of video tapes designed to provide information and elicit postviewing discussion concerning the professional liability of five specific medical specialties.

Each tape utilizes a talk show format with James E. George, M.D., J.D., Director of the Department of Professional Liability Control, as moderator and two physicians representing the medical specialty subject of the tape.

The five medical specialties which have the highest reported incidence of professional liability were selected for the initial thrust in the use of video tapes as a preventive and educational tool.

These 45-55 minute tapes are available from the Department of Professional Liability Control—rental fee \$45 each.

The titles are:

- Professional Liability and the Anesthesiologist
- Professional Liability and the General Surgeon
- Professional Liability and the Obstetrician/Gynecologist
- Professional Liability and Internal Medicine
- Professional Liability and the Orthopedic Surgeon

Each tape includes in its discussion the following topics: (1) General Assessment of Professional Liability, (2) Informed Consent, (3) Multiple-Physician Communication, (4) Group Practice, (5) Emergency Room Programs, and (6) The Three "Rs" of Malpractice Prevention. Category I AMA accreditation can be obtained if the video tapes are used as part of a planned program in conjunction with a moderator. Further information can be obtained from the Department of Professional Liability Control at the Medical Society of New Jersey—(609) 896-1766.

OKLAHOMA PROSPECTIVELY RECOGNIZES CAUSE OF ACTION BASED ON LACK OF INFORMED CONSENT

In *Scott v. Bradford*, 606 P2d 554 (Okla 1979), reh. den. (1980), the Court held that a physician or surgeon has a duty to disclose to a patient all relevant material information his patient will need to make an informed decision on whether to consent to or reject the physician's proposed treatment or surgery. In so ruling, the Court divided the cause of action based upon lack of informed consent into three elements: 1) duty to inform, 2) causation, and 3) injury.

Duty to Inform—The Court held that the disclosure must include alternatives to the proposed treatment and the risks of each course of action, including those risks inherent in foregoing all treatment. Disclosure was not to be measured by the custom of the physicians practicing in the community. The Court stated—that the scope of a physician's communications must be measured by his patient's need to know enough to enable him to make an intelligent choice. In other words, full disclosure of all material risks incident to treat-

ment must be made. There is no clear line separating the material from the immaterial. A risk is material if it would be likely to affect a patient's decision. When non-disclosure of a particular risk is open to debate, the issue is to be decided by the finder of facts, namely, the jury.

The court noted three exceptions to the duty to disclose which could be raised by the physician as an affirmative defense: (1) there is no need to disclose risks that ought to be known by everyone or already are known to the patient, (2) there is no need to disclose where full disclosure would be detrimental to the patient and (3) there is no need to disclose under emergency conditions.

Causation—The Court explained that the causation element requires proof that the plaintiff-patient would have chosen no treatment or a different course of treatment had the alternatives and material risks of each been known to him. Further, the Court adopted a subjective standard and rejected an objective standard. The Court wrote: "If a plaintiff testifies that he would have continued with the proposed treatment had he been adequately informed, the trial is over under either the subjective or objective approach. If he testifies he would not, then the causation problem must be resolved by examining the credibility of plaintiff's testimony. The jury must be instructed that it must find that the plaintiff would have refused treatment if the plaintiff is to prevail."

Injury—The Court observed that the undisclosed risk must actually materialize and the plaintiff must have been injured as a result of submitting to the treatment. Absent occurrence of the undisclosed risk, a physician's failure to reveal its possibility is not actionable. (*Personal Injury Newsletter*, Sept. 1, 1980, Vol 24, No. 5).

DID YOU KNOW

... New York's physician-owned company, Medical Liability Mutual Insurance Company, has been granted permission by the New York State Department of Insurance to increase its rates by an average of 24 percent.

... Aetna is threatening Connecticut physicians with a 70 percent rate hike.

... The "Practice Management" section of the October 27, 1980 issue of *Medical Economics* offered the following salient advice regarding delinquent accounts: "To reduce the number of delinquent accounts, you might follow these preventive measures: At the outset, discuss fees openly with patients. Have your receptionist request payment at time of service, and have her remind slowpayers of their debts over

^{*}This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

the phone. And when large bills present a hardship for patients, you might arrange installment payments."

... A newly formed physician-owned company in Washington, D.C. and the Minnesota Medical Insurance Exchange have joined the growing number of physician-owned insurance companies.

CASE STUDY

A 71-year-old widow had been a patient of a physician for five and a half years, during which time she had made 29 office visits. Throughout these office visits the physician had recorded the patient's weight, blood pressure, complaints of headaches, tiredness, essential hypertension, nausea, arthritis, and general aches and pains. During the length of care, no laboratory work-up, blood tests or urinalysis were performed and due to the patient's reluctance to undress or permit the touching of her breasts, no pelvic or breast examination was performed.

The patient's complaint of severe abdominal pain at the last office visit resulted in the physician's diagnosis of a gallbladder condition and the patient was admitted to the hospital with a diagnosis of cholecystitis.

The surgeon, in his initial evaluation, discovered a breast tumor which, mammographically, was typical of a malignant tumor. The gallbladder operation was deferred and the patient had a radical mastectomy which revealed advanced stage cancer. The patient's condition rapidly deteriorated

and she died within a few months.

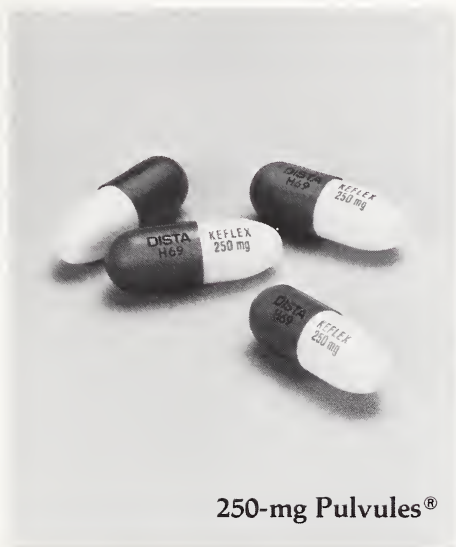
The autopsy report showed an infiltrating carcinoma of the stomach with metastatic cancer of the adrenals and extensive peritoneal seeding. The death certificate stated the immediate cause of death to be an intestinal obstruction due to metastatic carcinoma to the small bowel as a consequence of carcinoma of the breast.

A physician peer review found the case indefensible due to lack of satisfactory medical care. Peer review further revealed that in caring for a female patient, it was the duty of the physician to perform a breast examination at least twice a year, to inform the patient of self-examination, and/or to refer the patient for breast examination to a physician with whom the patient would be more comfortable in the performance of a breast examination.

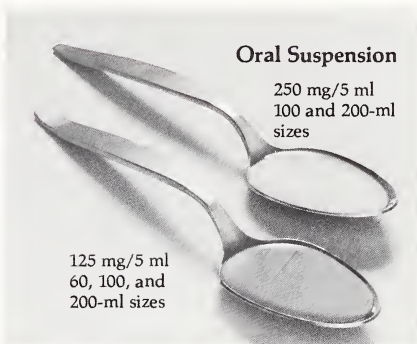
PHYSICIAN ALERT: Synthetic Hair Transplants

In November 1979, this "Commentary" alerted physicians to increased incidents and claims involving synthetic hair transplants. The Department of Professional Liability Control once again has been informed of a rash of claims concerning synthetic hair transplants. If you work for a synthetic hair transplant facility we urge you to consider your added exposure to claims for malpractice and to insist that the clinic carry its own malpractice insurance and name you as an additional insured.

easy to take



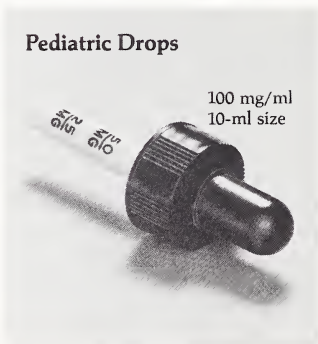
250-mg Pulvules®



Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes



Pediatric Drops

100 mg/ml
10-ml size

Keflex®

cephalexin

Additional information available
to the profession on request.



000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

INTRODUCING...

A NEW DIMENSION IN NUTRITIONAL ANALYSIS

Computerized Self-Assessment

The QUESTIONNAIRE, prepared by the patient, elicits a 30 day intake history of the foods currently being eaten, their frequencies and volumes. Additional data is gathered regarding the patient's living pattern and daily activity level.

It is clear, simple and structured for easy answering requiring only 15-20 minutes to prepare; yet is designed to yield a remarkably detailed and individualized profile of the patient's current dietary intake with a minimum of recall effort.

The NUTRITIONAL ANALYSIS REPORT is presented in the food exchange format detailing the patient's average daily intake of exchange units, calories, carbohydrates, protein, fat, cholesterol and other dietary components including saturated and unsaturated fat ratios. Comparisons are made to the Recommended Dietary Allowance (RDA) and personalized nutritional requirements based on activity level.

The form allows space for adjusting the patient's intake to a recommended diet based upon MODIFICATION of the patient's own food preferences and eating habits.

The system was designed for the medical and nutritional communities with the aid of the professional in that community.

Please send me additional
information on your Nutritional Analysis System.

NAME

ADDRESS

CITY

STATE

ZIP



701 Trinity Street, South Plainfield, New Jersey 07080
(201) 561-7000

Caution: I Brake for Unicorns

It came as a pleasant surprise to read the above warning on the rear of a "sixteen wheeler" hurrying along Route 95. The essence of humor is surprise, i.e., the unexpected.

It evoked an unpleasant response, however—and did not come as a surprise—when your editor read a report emanating from the federal government's general accounting office (GAO), which dealt with the quality of medical education received by American students in foreign medical schools.

American students who hope to enter the medical profession and fail to obtain admission to an approved medical school here have one of several courses: to continue with graduate education and research and keep on applying, to give up and enter a different field, or to look outside the United States for medical education. It is the latter situation which worries the GAO, an investigative unit of Congress, as well as many non-government groups including the Liaison Committee on Graduate Medical Education (LCGME), the AMA, the New York State Board of Regents, the Associated Medical Schools of New York and others.

From the students' point of view, the entire situation is tough. Rejection by American medical schools alone is frustrating and humiliating, but it is only the beginning. The student must investigate the overseas schools, concern himself with a foreign language (Spanish, Italian or French, mainly), apply and be accepted (which apparently is not difficult) and then come up with the tuition, travel and living expenses, which are formidable.

Once he has studied overseas and graduated, the U.S. foreign medical graduate faces additional education and training (the rules for which vary from state to state) before he can enter the mainstream of medicine in this country. This often means two or more years of study, presumably to make up for deficits in the foreign medical education. Of course, the American graduate of a foreign school ultimately faces the same examinations as the primary enrollee and graduate from Harvard, Johns Hopkins, CMDNJ, and all other United States medical schools.

From the point of view of American medical educators, state boards of medical examiners, administrators of postgraduate medical education programs and hospitals, the problem is different. They must concern themselves with students who presumably did not have the stuff (whatever that may be) to obtain acceptance to a United States school. Whether deserved or not, USFMGs tend to be looked down on for having been forced to study elsewhere. Furthermore, there is great uncertainty as to the process of overseas medical education. Until now, the American certifying and licensing agencies and medical institutions have been looking at the outcome or end product of foreign medical education, rather than the process and institution of learning. They have attempted to ascertain the knowledge and skills of the foreign medical graduate, using yardsticks based on American Medicine, to evaluate the applicant for a chair in organized medicine in this country—which some have re-

ferred to as the "medical industrial complex." This raises a large question in the minds of many, i.e., why not look at the foreign medical schools as well? We all know how difficult it is to be fair yet accurate in evaluating the end product of an educational experience—whether it be undergraduate, graduate or postgraduate level. And still the "Brownie" points are the same—CME credits, a license to practice medicine and surgery, specialty board certification and recertification, and so on.

Why did the government (GAO) get into the act? It seems that at least one Congressional Committee (the Subcommittee on Health and Environment of the House Committee on Interstate and Foreign Commerce) is interested. The mere numbers alone force them to be—about 10,000 to 12,000 American citizens are said to be studying in foreign medical schools. Simple arithmetic tells us that the financial drain out of this country each year represents hundreds of millions of dollars. Are these students getting their money's worth? Is the United States getting its money's work, i.e., a good medical doctor?

For the first time an official government agency, the GAO, took a look at a few of the overseas medical schools. Very few Americans study medicine in European schools, except in Bologna, Italy and Bordeaux, France; the majority are in Caribbean schools, the Dominican Republic, Grenada (West Indies) and Guadalajara (Mexico).

The conclusion of a study of six of the foreign medical schools was summarized by a representative of the GAO, Gregory J. Ahart, as follows:

"In our opinion, none of these foreign medical schools offered a medical education comparable to that available in the United States because of deficiencies in admission requirements, facilities and equipment, faculty, curriculum or clinical training."

In a way we now have a "good news-bad news" situation in the offing. If an official U.S. body examines and certifies the foreign medical schools—an extremely complex and sensitive task—it could make it better or worse for Americans seeking medical education outside the United States. Presumably, American graduates of accredited foreign medical schools will attain parity with graduates of American medical schools when it comes to licensure, postgraduate education and the like, when they return to the United States. On the other hand, students who enter non-accredited medical schools outside the United States may be in greater jeopardy than those students are under the present situation.

One plan—by the New York State Department of Education—would accredit foreign medical schools for either clerkship or licensure approval. In the former, the USFMG would complete a two-year clinical training experience in a teaching hospital in New York, after which he would have to pass the FMG licensure examinations. The graduates of licensure-approved foreign medical schools would have complete parity with graduates of American medical schools.

What has all this to do with the unicorn? It seems that the representatives of the AMA who appeared before the Congressional Subcommittee along with most representatives of medical groups agreed with the findings and recommendations of the study, but objected to the federal government's involvement in the accrediting program. This too is a good news-bad news situation, or, at least, a touchy one.

Is it the responsibility of American Medicine or individual states alone to accredit overseas medical schools? It is a formidable task now to accredit our own medical schools, hospitals, residency programs and postgraduate continuing education experiences. Are we capable, financially and otherwise to take on such a burden? Not likely.

It seems that here is an opportunity for the AMA to

involve itself in a positive way, along with representatives of other groups—LCGME, which accredits the 126 medical schools in the United States, the Colleges of Physicians and Surgeons and others. We do not want government to be accreditors of medical schools, but we need its money and its clout if accreditation of foreign schools is to be realistic. USFMGs need such consideration.

In this instance the AMA should not remain vigilant for unicorns, but should participate vigorously in a pragmatic way in this issue which involves so many thousands of American students and millions of dollars. The AMA should be a leader not a nay-sayer, when it comes to accreditation of foreign medical schools.

A.K.

The Ventnor Foundation

There were very few New Jersey physicians over the past 25 years who were not aware of the Ventnor Foundation and the role it played in the history of medical education and practice in this state.

Founded by Dr. Hilton S. Read (see letter, p. 64, this issue), a very active member of the Medical Society of New Jersey, the Ventnor Foundation was responsible for bringing 1,610 doctors from foreign countries to the United States—many to New Jersey—for a one-year internship. Read, who served as executive director from 1951 to 1967, was assisted by his wife, Kathryn S. Read, who was the organization's treasurer. The first president of the Foundation was Professor I.S. Ravdin, who served from 1952 until his death in 1966.

How and why it all started is best explained by Dr. Read himself:

"In 1951, Kathryn and I were on an official mission to visit five universities in Western Germany inquiring into the qualifications of graduates of their medical schools for licensure to practice medicine in the USA.

"In Berlin, we met Dr. Wilhelm Engert, director of a hospital in a converted bunker. He was one of the German citizens who had been to America under a State Department program for observation of the dynamics of our Christian-Judean democracy. He had returned to Germany unimpressed. His Hollywood-movie-inspired concept of our dollar diplomacy and Coca-Cola culture persisted.

"On the spot, Kathryn and I said we would take two of his recent graduates to Atlantic City Hospital, where I was Director of Medical Education, to observe the USA for a year without any window-dressing. They would work in our hospital as interns getting the same pay, doing the same work, having the same complaints as other interns. Then they would return to their homeland loving us or not loving us, but knowing us in depth.

"We did not promise them that everything would be better in the USA than in the homeland, but it would be different. If they took the best of their traditional culture and combined it with the best of our traditional culture and if they took the best of the medical discipline of the homeland and combined it with the best of the medical training in our land, they would be better world citizens and better physicians. We were not interested in future Americans. We were interested in world citizens dedicated to 'Waging Peace through Brotherhood and Better International Understanding.'"

The Ventnor Foundation operated entirely from contribu-

tions of Read's friends and patients and from a membership fee paid by the participating hospitals. There was no governmental aid, for this was a splendid example of voluntarism at its highest level. ("For 15 unsalaried years Kathryn and I did the administrative work with tons of volunteer help.")

How did it operate? This also is best described by the Reads:

"The Ventnor Foundation operates without any governmental aid and without any solicitation or appeal for funds. Friends and my patients volunteered funds and hospitals paid a membership fee. For 15 unsalaried years, Kathryn and I did the administrative work with tons of volunteer help. The 'exchanges' received no charity. They paid for their own transportation out of the meager salary they received which was the same as the USA interns received. They rendered meritorious service in the judgment of hundreds of chiefs of service, directors of medical education and hospital administrators to dozens of community hospitals in Pennsylvania, Delaware, New Jersey, and Massachusetts. Community hospitals rather than university hospitals were chosen by design. The program was to have a spiritual and cultural emphasis. Acquisition of some medical knowledge would be inescapable. It was our opinion that the university hospital, while it might offer superior medical training, almost certainly would offer a spiritual and cultural vacuum to the newly arrived doctor from another land. The Ventnor Foundation philosophy emphasized home visits, community activities, travel and shoulder-to-shoulder living and working for one year with citizens of the USA.

"Upon the completion of their training, we urged them to return to the homeland with no soapbox, Stars and Stripes or the Bill of Rights, but rather to "sing low" and prove by their work, instead of their words, what they had learned here."

Today, we no longer have the rotating internship of that earlier era. The Ventnor Foundation still exists, but no longer operates a physicians' exchange program. The Reads, however, still maintain the "foster family" concept with regular correspondence and annual meetings of the alumni of the Foundation program.

Certainly, the foreign medical graduates—many of whom returned to live and practice in New Jersey—and the citizens of New Jersey owe Hilton and Kathryn Read a debt of gratitude and a great deal of admiration for the genius of the concept and for the lifetime of devotion to such a worthwhile medical and community program.

A.K.

for "cardiac separation"...



Although over 80% of post-coronary patients can resume normal marital sexual activity, fear of anginal pain often results in "cardiac separation" between patients and their families.

You can help minimize "cardiac separation" with a program of

counseling and often, with a prescription for Cardilate® (erythrityl tetranitrate).

Cardilate® increases exercise tolerance, helps patients return to more normal levels of activity—including sexual activity. Sublingually, Cardilate begins to

work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to 2 hours.

counsel &
Cardilate®
(erythrityl tetranitrate)

CARDILATE® (ERYTHRITYL TETRANITRATE)

INDICATIONS: Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

CONTRAINDICATIONS: Idiosyncrasy to this drug.

WARNING: Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Intracocular pressure is increased; therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine, and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspira-

tion and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION

Oral/Sublingual Tablets. Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg. prior to each anticipated physical or emotional stress and a bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED:

CARDILATE (Erythrityl Tetranitrate) TABLETS (Scored)
for ORAL or SUBLINGUAL USE 5 mg. Bottle of 100
10 mg. Bottles of 100 and 1000. 15 mg. Bottle of 100

Reference 1 Hellerstein HK, Friedman EH. Sexual activity and the postcoronary patient. Arch Intern Med 125:987, 1970.

Burroughs Wellcome Co.,
Research Triangle Park, North Carolina 27709



DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide: In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android[®] / 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. mg. mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



JEMPAC'S GOAL 900 MEMBERS FOR 1981

In 1980, JEMPAC, through the cooperation of the county medical societies reached a membership of 580 physicians and their spouses. JEMPAC has set a goal of 900 members for the 1981 New Jersey gubernatorial election year.

JEMPAC continually encourages physician involvement in the political process. In a year when the voters of New Jersey decide who will occupy the State's Executive Office, stronger emphasis is being placed on physicians' political involvement. The greater the membership JEMPAC has, the greater its impact can be on favorably assisting those who physicians believe are more closely aligned to their philosophies regarding good health care for the citizenry.

JEMPAC's goal is to achieve for the physicians of MSNJ the greatest favorable exposure to those in the political arena. When physicians are recognized as a viable united force it becomes easier to express views to those who will have an effect on and who will enact legislation that will have a direct impact on the practice of medicine.

JEMPAC has mailed a newly revised brochure to all MSNJ members. In addition a number of county societies have graciously included JEMPAC membership in their annual billing. JEMPAC fervently hopes that those physicians and their spouses who have been members will continue as such and that they will encourage their colleagues to support the political action committee of MSNJ.

SEVENTEEN CROWD EARLY
FIELD FOR NEW JERSEY GOVERNOR

The last date for filing to enter the primary election for Governor of New Jersey is April 23, 1981. The race is off to a crowded start with promise of more candidates entering the field before the deadline. The following list of potential candidates does not include cabinet members who are under a directive not to campaign at this time.

Of the current seventeen potential candidates, thirteen are presently in an elective office—three are members of Congress, five are members of the State Senate, two are members of the State Assembly and three are mayors.

Democrats

- Herbert J. Buehler, West Allenhurst
Birthdate: April 10, 1927 Career: Educator
- Frank J. Dodd, Orange
Birthdate: February 4, 1938 Career: Businessman
Current Position: State Senator, 26th District
- James J. Florio, Camden
Birthdate: August 29, 1937 Career: Attorney
Current Position: U.S. Congressman, 1st District
- William J. Hamilton, New Brunswick
Birthdate: December 26, 1932 Career: Attorney
Current Position: State Senator, 17th District
- Barbara W. McConnell, Flemington
Birthdate: October 5, 1938 Career: NJ State Assemblywoman
Current Position: Assemblywoman, 14th District

- Joseph P. Merlino, Trenton
Birthdate: July 15, 1922 Career: Attorney
Current Position: President NJ Senate
- Robert A. Roe, Wayne
Birthdate: February 28, 1924 Career: U.S. Congressman
Current Position: U.S. Congressman, 8th District
- Thomas F. X. Smith, Jersey City
Birthdate: July 5, 1927 Career: Mayor of Jersey City
Current Position: Mayor of Jersey City

Republicans

- Donald J. Albanese, Phillipsburg
Birthdate: June 26, 1937 Career: Certified Public Accountant
Current Position: State Assemblyman, 15th District
- Thomas Kean, Livingston
Birthdate: April 21, 1935 Career: Businessman
Current Position: President, Realty Transfer Co.
- Lawrence F. Kramer, Paterson
Birthdate: February 24, 1933 Career: Mayor of Paterson
Current Position: Mayor of Paterson
- Richard B. McGlynn, Short Hills
Birthdate: December 16, 1938 Career: Attorney
Current Position: Public Utilities Commissioner
- Barry T. Parker, Mount Holly
Birthdate: December 12, 1932 Career: Attorney
Current Position: Minority Leader of Senate
- John K. Rafferty, Hamilton Township
Birthdate: May 1, 1938 Career: Mayor of Hamilton Township
Current Position: Mayor of Hamilton Township
- Matthew J. Rinaldo, Union
Birthdate: September 1, 1931 Career: U.S. Congressman
Current Position: U.S. Congressman, 12th District
- Joseph A. Sullivan, Essex Fells
Birthdate: February 10, 1937 Career: Business Executive
Current Position: President, Bomant Industries
- James H. Wallwork, Millburn
Birthdate: September 17, 1930 Career: Wholesale Distribution Executive
Current Position: Assistant Minority Leader of Senate

MSNJ's POSITION ON PROPOSED NJ LEGISLATION

Assembly-322-Richard F. Visotcky, (36th District, part of Bergen)

To authorize the State Board of Higher Education to contract with any and all podiatry colleges in good standing with the New Jersey State Board of Medical Examiners for acceptance of students who are New Jersey residents. **ACTIVE OPPOSITION**, because the need for this legislation has not been demonstrated and its cost would be an unnecessary burden on the taxpayers of New Jersey. Assigned to **Education Committee**; Albert Burstein, chairman, Mildred Barry Garvin, vice-chairman, Joseph V. Doria, Jr., William J. Bate, Marie S. Muhler, John A. Rocco, H. James Saxton.

We urge you to write to the sponsors, the committee, and committee members to make MSNJ's views known—State House, Trenton, NJ 08625.

* Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

Modern Concepts of Scoliosis Bracing*

ROBERT FERNAND, M.D., A.E. STEFANELLI, M.D.
and B. ERNST, C.P., Newark

The principles of scoliosis bracing are discussed and two braces, the Milwaukee and the underarm type are described.

It has been a quarter of a century since the development of the Milwaukee Brace (MB) for the treatment of scoliosis. Blount and Schmidt, closely followed by Moe were the pioneers in the brace treatment.¹ The MB, which originally was designed for postoperative immobilization, quickly was adapted to active treatment and was modified to avoid complications, as well as to enlarge its potential for treatment of practically all types of spine deformity (Figure 1).

In the past several years (beginning in Europe) considerable enthusiasm and experience has been gained with the so-called underarm brace. In this country the "Lexon's" jacket of Pasadena, the "Boston Brace" and the TLSO of Twin Cities, Minnesota are examples of this type of brace (Figure 2). The underarm differs structurally from the MB because of the lack of upright, occipital pad and throat mold, and functionally by relying on "passive" forces exclusively for curve correction.^{2,3} The MB allows "dynamic" or "active" exercises within the brace.

INDICATIONS AND RATIONALE OF BRACE TREATMENT

In general there are two conditions which must be fulfilled for any brace treatment to be effective:

1. The patient is skeletally immature.
2. The curvature is mild to moderate: between 20° and 40° (occasionally up to 50°).

If these conditions are met the child is suitable for brace treatment. The rationale for the first condition is obvious. Growth potential is needed to allow the spine to grow within the corrected positions obtained by bracing. Additionally a mature patient will not increase his curvature to a significant degree during the one to three years that a brace would be used. The choice in a mature individual is between no treatment or surgery; a brace is not indicated.

The second condition arises as a result of numerous clinical observations by Blount, Moe, Edmonson and others.^{4,5} Where the curvature is 20° or less it can be observed in a growing child, without need for treatment. The majority of these curves will not increase. For spinal curvature between 20° and 40° the results of bracing are the best. Biomechanical studies by White and Ponjabi⁶ demonstrated that two correcting forces act on the MB—an axial force between the pelvis and the occipital pads and a transverse force between the "L pad" on one side and the neck ring and pelvis on the other side. Mathematical analysis of these forces has shown that curves over 53° are corrected mainly by axial forces, transverse force being ineffective. For curves below 53° the opposite is true. Direct measurement by Galante and others partially confirmed White and Ponjabi's analysis.⁷

*From the Spinal Deformity Center, United Hospitals Orthopedic Center, Newark. Correspondence may be addressed to Dr. Fernand at the Center, 89 Park Avenue, Newark, NJ 07104.



Figure 1—Milwaukee Brace. Note the "L" pad on the right and the lumbar pad on the left.

Axial forces had to be reduced to avoid the deleterious effects of MB on the mandible. The only effective and safe force that can be used with a brace is the transverse force which sets the practical upper limits of brace treatment at 50°. These general principles must be applied to individual cases while taking into consideration the etiology of the curve, the degree of structural changes, the clinical appearance, the location of the deformity, any associated conditions and last but not least, acceptability of the brace to the patient.

Some of the factors mentioned above can change a given program of treatment considerably. For example: A 12-year-old patient with a 25° curve that progresses to 35° over a one-year period refuses to wear a brace. Here surgery is indicated. If the same patient presented for the first time with a similar 35° curve and a deformity which was not acceptable to the parents or patient, the prescription of a brace would be unwise. After two to three years of brace treatment the patient would have the same deformity which was unacceptable before brace treatment. Surgery would be a better alternative. On the other hand, a 12-year-old patient with a 40° to 45° double major curve which is clinically acceptable can be treated safely until maturity with a brace.

PRESCRIPTION OF A SCOLIOSIS BRACE

The following steps should be taken for the prescription of a scoliosis brace.

1. Thorough history and physical examination.
2. High quality x-rays of the entire spine and bone age. A



Figure 2—Modified thoracolumbosacral orthosis (T.L.S.O.). Note lack of uprights and throat mold.

14 x 34 film and variable intensity grid are highly recommended.

3. Accurate measurement of curvature(s).
4. Thorough explanation to the patient and family of purpose and expected results with brace treatment.
5. Prescription to an orthotist who is experienced with this type of bracing. Simultaneous examination of patient, and x-ray by the physician and orthotist is very helpful.

The following table compares the advantages and disadvantages.

Brace	Advantages	Disadvantages
Milwaukee Brace	Use all curves	Heavier
	Dynamic force (allows exercises)	Cosmetically less acceptable
	Maintains muscle tone	Restricts head-neck motion
	Axial transverse forces are effective	Potentially dangerous to others
		Requires special clothing
Under Arm Brace	Cosmetically more acceptable	Cannot be used curves above T ₉
	Lighter	May produce muscle atrophy and "funnel" chest
	No special clothing	Passive forces only



Figure 3—Patient with T.L.S.O.

vantages of the Milwaukee and Under Arm braces. Both braces produce similar results if properly used. The authors presently prefer the underarm type because it is better accepted by the patient who wears it more faithfully (Figures 3 and 4).

SUMMARY

The dominance of the Milwaukee brace as the conservative treatment of scoliosis is being challenged by the "Underarm Brace." This is the result of patient performance



Figure 4—Patient dressed wearing T.L.S.O.

and realization by biomechanical analysis that the main correcting force on a brace is a transverse force exerted by the lateral pad.

REFERENCES

1. Blount WP, Moe JH: *The Milwaukee Brace*. Baltimore, Williams and Wilkins, 1973.
2. Winter RB, Carlson JM: Modern orthotics for spinal deformities. *Clin Orthop and Rel Res* 126:874-876, 1977.
3. Klatts HG, Hall JE, Stamish Wm: The Boston brace system. *Clin Orthop and Rel Res* 126:87-92, 1977.
4. Edmonson AG, Morris JT: Followup study of MB treatment. *Clin Orthop and Rel Res* 126:58-61, 1977.
5. Mellencape DD, Blount WP, Anderson J: M.S. Milwaukee brace treatment of idiopathic scoliosis. *Clin Orthop and Rel Res* 126:47-57, 1977.
6. White AA III, Ponjabi MD: The clinical biomechanics of scoliosis. *Clin Orthop and Rel Res* 118:100-111, 1976.
7. Mulcahny T, Galente J, Dibald R, Shultz A, Hunter JC: A followup study of forces acting on Milwaukee brace. *Clin Orthop and Rel Res* 93:53-68, 1973.

a group major medical plan for doctors

Officially Endorsed by The Medical Society of New Jersey

**BROAD COVERAGE
COMPETITIVE RATES
OPEN ENROLLMENT
JUNE AND DECEMBER**

For More Information Contact

Donald F. Smith and Associates

1 Airport Place, Route 206 North, P.O. Box 2197 • Princeton, New Jersey 08540 • (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross-Blue Shield

Diagnosis: obsolete patient billing procedures Treatment: Universal Billing Systems

If your billing procedures haven't kept pace with your practice, it's time to talk to Universal Billing Systems. At Universal, we're specialists in computerized billing for the medical profession. Whether you're a solo practitioner or part of a group or clinical practice, we can customize a low-cost billing system to meet your exact needs. And we do it all! We print monthly statements and mail them directly to your patients. (The payments come to **you!**) We provide you with up-to-date **weekly** activity reports. Even eliminate the need for filling out time-consuming 3rd-party insurance forms. Universal Billing Systems can

- reduce labor costs
- increase billing efficiency
- speed cash flow
- eliminate billing delays caused by photocopying of bills and statements
- bring your patient billing system into the 80's

Best of all, your patients receive full details of every transaction including types of services rendered and types of payments received. This greatly reduces telephone inquiries to your office. And . . . your medical assistants require no special training to submit billing data to Universal. Write or phone for full details!



UNIVERSAL BILLING SYSTEMS

4 BANTA PLACE • HACKENSACK, N.J. 07601 • 487-8636

Ultrasonic Imaging of the Cervical Carotid Arteries*

ROBERT W. HOBSON, II, M.D., Newark

SILVIA M. BERRY, M.Sc., and CHARLES E. MARSTERS, P.A., East Orange

ANDREW S. KATOCS, JR., Ph.D., and J. PHILIP SAVITSKY, M.D., Pearl River, NY

Pulsed Doppler and real-time B-mode ultrasonography are presented as two techniques for noninvasive visualization of the carotid bifurcation. Ultrasonograms were compared with contrast arteriograms in a group of patients undergoing contrast arteriography for clinical evaluation of suspected extracranial carotid disease. Both techniques accurately describe the normal carotid artery. Although the estimation of percent stenosis was somewhat better with B-mode ultrasonography, the identification of the occluded internal carotid artery was accomplished better with pulsed Doppler ultrasonography.

Noninvasive visualization of the cervical carotid artery by ultrasonic techniques has become increasingly available to clinicians during the last several years. Both pulsed¹⁻³ and continuous wave^{6,8} Doppler instruments have been used for this purpose. Real-time B-mode ultrasonography also has been studied^{9,11}, while more recently a combination of pulsed Doppler and B-mode imaging, duplex scanning, has been evaluated^{14,15}. However, there have been few clinical reports outlining the application and accuracy of these devices.

Our group reported an initial clinical evaluation of B-mode ultrasonography for carotid imaging.¹⁰ The purpose of this report is to update and compare our further experience with real-time B-mode as well as pulsed Doppler ultrasonography for visualization of the extracranial carotid arteries.

CLINICAL MATERIAL AND RESULTS

Real-time B-mode and pulsed Doppler ultrasonography were used for the noninvasive visualization of the carotid bifurcation in patients referred to the vascular laboratory for evaluation of symptoms suggestive of extracranial cerebrovascular insufficiency. Patients were placed in a comfortable supine position and images produced with a pulsed Doppler instrument (Figure 1) designed by Hokanson and associates.³ Polaroid photographs were taken of the carotid image from a storage oscilloscope for the patient's permanent record. The same patients also were scanned with

the B-mode device developed by engineers at the New York Institute of Technology's Science and Research Center in Dania, Florida.¹⁶

The prototype transducer of this 6.0-11.0 MHz ultrasound unit (Figure 2) is hand-held by the clinician and passed along the neck on a line just anterior to the sternocleidomastoid muscle for visualization of the carotid arteries. The transducer, with its self-contained water bath, consists of an emitting and receiving piezoelectric crystal with a high-speed mechanical deflecting system. Real-time high resolution gray-scale images of the carotid artery were projected and magnified on a monitor with a lateral resolution of 0.5 mm

*This report is from the Veterans Administration Medical Center, East Orange, New Jersey, the Division of Vascular Surgery, CMDNJ-New Jersey Medical School, Newark, New Jersey, and Lederle Laboratories, Pearl River, New York. Dr. Hobson is Chief, VA Surgical Service, East Orange, and Associate Professor of Surgery and Director, Division of Vascular Surgery, CMDNJ-NJ Medical School, Newark. Ms. Berry is Chief, Noninvasive Vascular Laboratory at the VA facility in East Orange and Associate, Division of Vascular Surgery, NJMS, Newark. Mr. Marsters is affiliated with the Vascular Laboratory at the VA's East Orange Medical Center. Drs. Katocs and Savitsky are, respectively, in the Metabolic Disease Research Section and Associate Director, Clinical Pharmacology at Lederle Laboratories' Pearl River, New York facility. The report was presented at the International Cardiovascular Congress II: Noninvasive Diagnosis, Scottsdale, Arizona on February 20, 1979. Correspondence may be addressed to Dr. Hobson at the Division of Vascular Surgery, CMDNJ-NJMS, 100 Bergen St., Newark, NJ 07103.



Figure 1—An artist's conception of the pulsed Doppler probe as it is passed along the neck for visualization of the common, external and internal carotid arteries.

near the focal length of 2.5 cm. Video tapes were made for subsequent analysis as reported in our preliminary clinical evaluation.¹⁰ Individual video tape frames then were photographed with a 35 mm camera for comparison with contrast arteriograms.

All patients reviewed in this report also had selective biplanar contrast arteriography performed for clinical indications with direct measurement of percent stenosis obtained by comparing cross-sectional measurements at the narrowest point in the stenotic lesion with similar measurements above the lesion in the internal carotid artery. Arteries were classified angiographically as normal, less than 50 percent stenosis, greater than 50 percent stenosis and occlusion. Similar measurements and classifications were made from the ultrasonograms and comparisons were made as to accuracy of the noninvasive technique.

Examples of the clinical applications of both noninvasive ultrasonic imaging techniques were presented in Figures 3, 4 and 5. The first patient (Figure 3) is a 66-year-old male who underwent contrast arteriography after recovering from a stroke. Arteriography demonstrated arterial wall irregularities at the origin of the internal and external carotid arteries but was otherwise normal. The pulsed Doppler image showed an "echo-free" area which probably was related to calcific deposits within the atherosclerotic plaque reducing the transmission of ultrasound.¹⁷ The real-time image showed the internal carotid artery to be normal but did demonstrate an area of high acoustical reflectivity at the bifurcation narrowing the lumen by 20 percent. In this case, contrast arteriography may have been avoided with information obtained from the B-mode image. This case also demonstrates the problem encountered in ultrasonic imaging when calcific deposits within a plaque reduce transmission of ultrasound as demonstrated in the pulsed Doppler image.

The second patient (Figure 4) is a 65-year-old male who presented with transient episodes of lightheadedness and right amaurosis fugax. Contrast arteriography demonstrated an 80 percent stenosis of the right common carotid artery 1.5 cms below an essentially normal bifurcation. In this case,

"Real-time B-mode and pulsed Doppler ultrasonography were used for the noninvasive visualization of the carotid bifurcation . . . for evaluation of symptoms suggestive of extracranial cerebrovascular insufficiency. . . ."

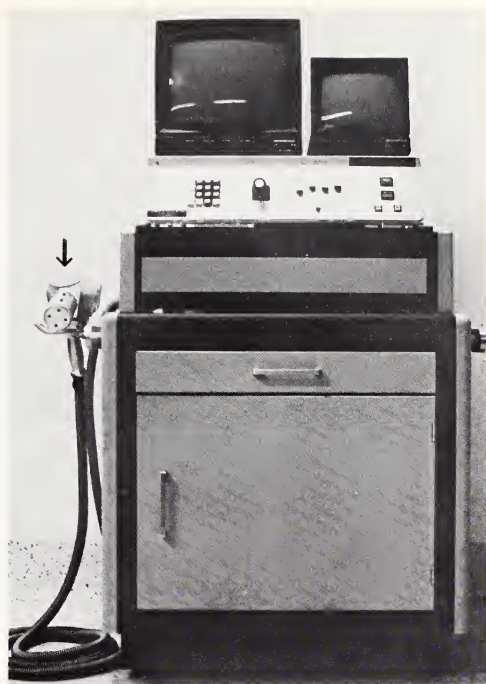


Figure 2—The B-mode ultrasonic imaging device is shown. Real-time images are presented on the monitor. The prototype transducer is shown (arrow).

the pulsed Doppler image provided an accurate appraisal of flow within the common carotid artery and confirmed the high-grade stenosis, while the real-time image also confirmed the location of the lesion as well as the relationship of the atherosclerotic plaque to the arterial wall. Although both techniques accurately diagnosed the lesion, studies on the natural history of carotid atherosclerotic disease and its relationship to diet or medical therapy may be assisted by the use of B-mode ultrasonography.

The third patient (Figure 5) is a 61-year-old male with symptoms of headache and intermittent vertigo. Contrast arteriography demonstrated bilateral occlusion of the internal carotid arteries which was confirmed by pulsed Doppler ultrasonography; however, these occlusions were not confirmed on B-mode ultrasonography. As can be noted from the accompanying accuracy data, pulsed Doppler ultrasonography was the more accurate technique for the diagnosis of occlusion.

" . . . ultrasonic imaging potentially allows direct quantitation of the atherosclerotic plaque's size and its relationship to the arterial wall. . . ."

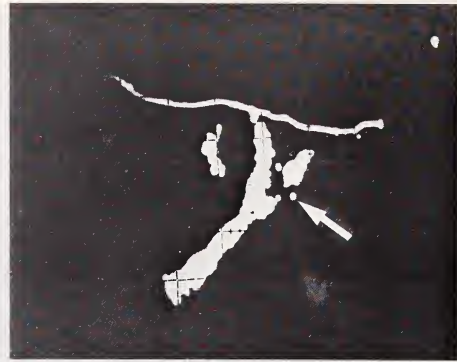


Figure 3—An “echo-free” area (arrow) is shown in the pulsed Doppler ultrasonogram (upper right). A high reflectivity plaque (arrow) is seen on the real-time image (lower right).

Accuracy of each technique is summarized in Table 1. Normal arteries were confirmed accurately by both techniques. Although the determination of percent stenosis was somewhat more accurate with the B-mode technique, the diagnosis of occlusion was significantly more accurate by the pulsed Doppler technique. As noted in Figure 2, reduced transmission of the ultrasonic signal was a major impediment to accurate determination of percent stenosis, as was seen in 8.2 percent of pulsed Doppler images and 18 percent of B-mode images.¹⁸

DISCUSSION

Ultimate application of ultrasonic carotid imaging in clinical assessment of patients with symptomatic and asymptomatic extracranial carotid arterial disease will depend upon its accuracy and relative merits as compared with other noninvasive techniques such as directional Doppler¹⁹ and oculoplethysmography.^{20,21} These latter two techniques are indirect methods for assessing hemodynamic significance of internal carotid arterial stenoses, while ultrasonic imaging potentially allows direct quantitation of the atherosclerotic plaque's size and its relationship to the arterial wall. Avoiding hazards associated with contrast arteriography has become the primary impetus for development of imaging techniques. Although ultrasonic imaging is more investigational, further refinements in such direct methods will be necessary if we are to reduce the need for arteriography in selected patients.

Several authors have reported on the pulsed Doppler imaging technique.¹⁻⁵ Barnes reported high diagnostic ac-

curacy¹; however, spectral analysis of the Doppler audio signal was necessary to improve the accuracy of determining percent stenosis. Strandness also used the technique but reported a 17 percent incidence of falsely negative results.¹⁵ This high rate of falsely negative results (14 percent in the current series) has resulted in concern regarding accurate determination of percent stenosis. However, the real-time B-mode technique appears to be somewhat more accurate (Table 1). Conversely, the diagnosis of occlusion can be made accurately by pulsed Doppler ultrasonography making its combination with oculoplethysmography²² helpful since the latter technique can identify hemodynamically significant stenoses but cannot distinguish high-grade stenosis from occlusion.

Selected cases in this report demonstrate the usefulness of B-mode scanning. The case presented in Figure 4 confirmed the degree of arterial stenosis but also defined ultrasonic morphology of the atherosclerotic plaque. Alteration in the plaque caused by medical or diet therapy should be reflected in the ultrasonogram, suggesting use of this instrumentation in studies concerning evolution of the carotid atherosclerotic disease. Clinical applications may be limited by the same considerations as noted with pulsed Doppler ultrasonography. Although determination of percent stenosis was somewhat more accurate with B-mode scanning, reduction in ultrasonic signal transmission by high density atherosclerotic plaques is also a problem with the method.¹⁸ This may result in enough obscure images to reduce significantly the accuracy of this determination. Although Strandness has combined B-mode scanning with pulsed Doppler technology

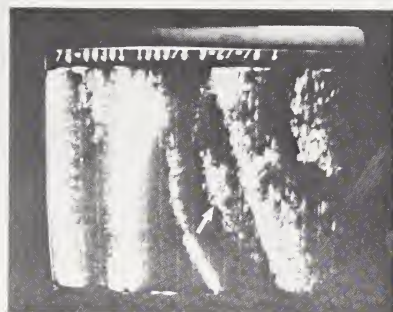


Figure 4—Contrast arteriography using a subtraction technique demonstrated an 80% stenosis of the right common carotid artery. While the pulsed Doppler image (upper right) demonstrated the stenosis (arrow) as a disturbance of blood flow, the B-mode image (lower right) defined the relationship of the atherosclerotic plaque (arrow) to the arterial wall. (Courtesy: The C.V. Mosby Company, St. Louis, MO; Hobson, R.W. *et al. Surgery*, 87:286, 1980).

(duplex scanning), accuracy in preliminary clinical evaluation has not been improved over pulsed Doppler imaging alone.¹⁵

A discussion on clinical applications of this technology must include the realization that patients with typical lateralizing transient ischemic episodes require contrast arteriography regardless of the results of noninvasive testing. Contrast arteriography would still be required in most symptomatic patients, even with a normal cervical carotid artery on ultrasonic imaging due to current recommendation for visualization of the intracranial circulation in these patients. However, a large number of patients may be

benefited from these techniques. Patients with asymptomatic carotid stenosis referred for evaluation of carotid bruits or non-lateralizing symptoms such as lightheadedness and dizziness are examples. Ultrasonic confirmation of a normal bifurcation in such a patient scheduled for a major abdominal vascular procedure also would avoid the need for contrast arteriography. Preangiographic identification of an occluded internal carotid artery could limit need for further contrast arteriography in selected patients. Repeated evaluation of the artery also would be feasible after carotid endarterectomy or as part of a study of the natural history of carotid bifurcation disease.

“ . . . the diagnosis of occlusion can be made accurately by pulsed Doppler ultrasonography . . . ”

“ . . . reduction in ultrasonic signal transmission by high density atherosclerotic plaques is a problem . . . ”

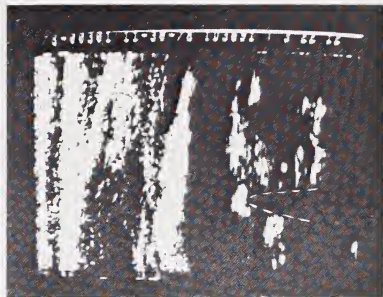
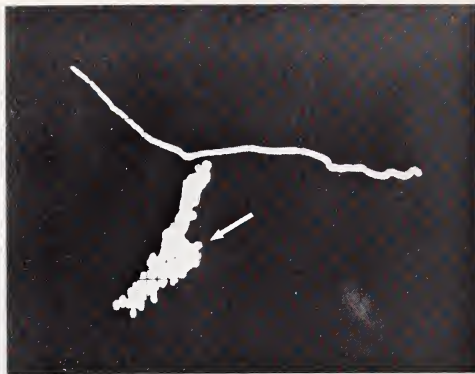


Figure 5—Contrast arteriography demonstrated bilateral internal carotid occlusions (left occlusion shown in this selective arteriogram). These occlusions were confirmed by pulsed Doppler ultrasonography. The pulsed Doppler ultrasonogram of the left internal carotid occlusion is presented (upper right). The B-mode image (lower right) was obscured at the level of bifurcation making diagnosis of occlusion inaccurate.

Table 1*
Comparison of results with pulsed Doppler and B-mode echo arteriography in 43 patients (84 arteries)

Arteriogram	Pulsed Doppler*					B-Mode**				
	Normal	<50%	>50%	Occlusion	Accuracy (%)	Normal	<50%	>50%	Occlusion	Accuracy (%)
Normal (n = 37)	30	2	2	0	81	30	2	1	0	81
<50% (n = 18)	5	9	1	0	50	3	14	0	0	78
>50% (n = 12)	0	2	5	3	42	1	2	7	0	58
Occlusion (n = 17)	00	0	0	17	100	2	4	2	3	18

* False +, 6/55 = 11%

* False -, 4/29 = 14%

* Sensitivity = 86%

* Specificity = 87%

** False +, 6/55 = 11%

** False -, 16/29 = 59%

** Sensitivity = 41%

** Specificity = 89%

*Modified form: Hobson, R.W. et al: Comparison of pulsed Doppler and real-time B-mode echo arteriography for non-invasive imaging of the extracranial carotid arteries. *Surgery*, 87:286, 1980. CV Mosley Co., St. Louis, MO.

SUMMARY

Pulsed Doppler and real-time B-mode ultrasonography are presented as two techniques for noninvasive visualization of the carotid bifurcation. Ultrasonograms were compared with contrast arteriograms in a group of patients undergoing contrast arteriography for clinical evaluation of suspected extracranial carotid disease. Both techniques accurately de-

scribe the normal carotid artery. Although the estimation of percent stenosis was somewhat better with B-mode ultrasonography, identification of the occluded internal carotid artery was better accomplished with pulsed Doppler ultrasonography.

Potential clinical applications of carotid ultrasonography include preoperative evaluation of patients with

asymptomatic carotid stenosis or non-lateralizing symptomatology who are scheduled for major vascular surgery or operative procedures on the heart, and for evaluation of asymptomatic or minimally symptomatic patients referred for appraisal of cervical bruits. Some patients with pre-angiographic diagnosis of total occlusion, as well as patients after endarterectomy who may have developed recurrent stenosis, may benefit from the study. Although patients with lateralizing neurological symptoms usually require contrast arteriography, carotid ultrasonography may reduce the need for that invasive procedure in selected patients.

REFERENCES

1. Barnes RW, Bone GE, Runerston J, Staymaker EE, Hokanson DE, Strandness DE: Noninvasive ultrasonic carotid angiography: Prospective validation by contrast arteriography. *Surg* 80:328, 1976.
2. Berry SM, Jamil Z, O'Donnell JA, Hobson RW II: Capabilities and limitations of an ultrasonic imager in diagnosis of extracranial carotid occlusive disease. *Proceedings of the 23rd Annual Meeting, American Institute of Ultrasound in Medicine*, pg 142, 1978.
3. Hokanson DE, Mozersky D, Sumner DS, Strandness DE, Jr: Ultrasonic arteriography: A new approach to arterial visualization. *Biomed Engng* 6:420, 1971.
4. Mozersky DJ, Hokanson DE, Sumner DS, Strandness DE Jr: Ultrasonic visualization of the arterial lumen. *Surg* 72:253, 1972.
5. Strandness DE Jr, Mozersky DJ, Sumner DS, Baker DW, Hokanson DE: Noninvasive arteriography: A new approach for arterial visualization. *Am Surg* 38:494, 1972.
6. Spencer MP, Reid JM, Paulson PS: Cervical carotid imaging with a continuous wave Doppler flowmeter. *Stroke* 5:145, 1974.
7. Reid JM, Spencer MP: Ultrasonic Doppler technique for imaging blood vessels. *Science* 176:1235, 1972.
8. Thomas GI, Spenser MP, Jones TW, Edmark KW, Stavney LS: Noninvasive carotid bifurcation mapping. *Am J Surg* 128:168, 1974.
9. Ackerman RH, Pryor DS, Vigeault L, Traveras JM: Real-time imaging of the carotid artery. *Proceedings of the 23rd Annual Meeting, American Institute of Ultrasound in Medicine*, pg 103, 1978.
10. Hobson RW II, Lipp JA, O'Donnell JA: Real-time ultrasonic arteriography of the extracranial carotid artery, in EB Diethrich (ed): *Noninvasive Cardiovascular Diagnosis: Current Concepts*. Baltimore, University Park Press, 1978, ch 4.
11. Lipp JA, Solomon KR, O'Donnell JA, Hobson RW II: Real-time ultrasonic arteriography of the carotid artery. *Clin Res* 25:235, 1977.
12. Katocs AS Jr, Schaffer SA: Detection of atherosclerotic lesions in rabbit aorta by real-time ultrasonography. *Circulation* 58 (II):129, 1978.
13. Green, PS, Taenzer JC, Ramsey SC, et al: Real-time ultrasonic imaging system for carotid arteriography. *Ultras Med Biol* 3:129, 1977.
14. Barker RE, Baker DW, Nation AWC, Strandness DE, Reid JN: Ultrasonic duplex echo-Doppler scanner. *IEEE Transac Biomed Eng* 21:109, 1974.
15. Strandness DE, Ward KJ, Phillips DJ, Harley JD: Recent aspects of ultrasonic techniques, in HA Kriessmann and A Bollanger (eds): *Clinical Angiology, Ultraschall-Doppler-Diagnostic in der Angiologie*. Stuttgart, Germany, Georg Thieme Vxrlag, 1978, pp. 82-89.
16. Glenn WF, Solomon K, Marcinka J: Personal communications.
17. Hartleg CJ, Strandness DE Jr: The effects of atherosclerosis on the transmission of ultrasound. *J Surg Res* 9:576, 1969.
18. Hobson RW II, Berry SM, Katocs AS, O'Donnell JA, Jamil Z, Savitsky JP: Comparison of pulsed Doppler and real-time echo arteriography for noninvasive imaging of the extracranial carotid arteries. *Surg* 87:286, 1980.
19. Brockenbrough EC: Screening for prevention of strokes: Use of a Doppler flowmeter. Parks Electronics, Beaverton, Ore., 1970.
20. Gee W, Mehigan JT, Wylie EJ: Measurement of collateral hemispheric blood pressure by ocular pneumoplethysmography. *Am J Surg* 130:121, 1975.
21. Kartchner MM, McRae LP, Morrison FD: Noninvasive detection and evaluation of carotid occlusive disease. *Arch Surg* 106:528, 1973.
22. Ghosh A, Abou-Samra S, Berry SM, Hobson RW II: Evaluation of extracranial carotid occlusive disease with directional Doppler, fluid-filled oculoplethysmography, carotid phonoangiography and pulsed Doppler imaging. *Curr Surg* 37:128, 1980.

Immunotherapy: The Unfulfilled Promise*

RALPH S. GRECO, M.D., Piscataway

The application of adoptive and active immunotherapy to human solid tumors has become increasingly commonplace. The basic hypotheses of tumor immunotherapy are discussed as well as its application to a number of human malignancies. Although the results generally are equivocal, noteworthy exceptions exist. The expectation that immunotherapy will become a useful adjunct to conventional cytoreductive therapy is reviewed.

During the last 15 years, interest in immunotherapy has increased geometrically as evidenced by the twenty-fold increase in publications in tumor immunology from 1965 to 1979. The history of immunotherapy dates back to the late 19th and early 20th century when studies utilizing tumor vaccines first were done by Hericourt, Leyden, Contamin and Chambers. These studies were abandoned when it was realized that the results represented histoincompatibility rather than tumor immunity. The evolution of tumor immunity awaited the development of syngeneic strains of mice and the sophisticated *in vitro* assay techniques that are now a daily part of the immunological laboratory.

The central hypothesis of tumor immunology is the theory of immunological surveillance. Simply stated, the theory suggests that the *raison d'être* of cellular immunity is a surveillance system against mutations in multicellular organisms which occur spontaneously and are suppressed by sensitized cells. Therefore, malignancy occurs *in vivo* at a cellular level far more frequently than does clinical cancer. Put another way, immune surveillance postulates that normal cells become malignant frequently. These malignant cells form neoantigens recognized by the host as foreign and are then destroyed. A number of factors support the concept of immunological surveillance. Malignancy is well known to be greatest in the young and in the old when immunocompetence is generally less active. Malignancy is greater in the naturally and the iatrogenically immunodeficient. Spontane-

ous tumor regression has been noted in a variety of reports. There is a long interval in many human cancers between the development of the primary and later recurrence. Histologically, similar tumors behave differently among patients. Finally, it often is observed that tumor cells can be found in peripheral blood during operations that result in cures. This, of course, presents a paradox to the tumor immunologist. The preponderance of evidence suggests immunity and we then must ask why tumors continue to evolve, metastasize and kill the seemingly well armed host.

A number of theories have been designed to explain this paradox. Some question the validity of the theory and others attempt to explain the failure through a variety of immunological mechanisms. Evidence has been obtained that tumor antigens are weak antigens and, as such, are poor initiators of an immune response. Still other theories have propounded the possibility that the tumor cells are protected from the killer cells by a variety of mechanisms including immune complexes and blocking factors.

A different interpretation of immune surveillance questions the validity of the basic hypothesis. It points out that most tumors in the immunodeficient patient are lymphoreticular and that this may represent a failure, not of

*From the Department of Surgery, CMDNJ-Rutgers Medical School, Piscataway, N.J., where Dr. Greco is associate professor of surgery in the Division of General Surgery. Correspondence may be addressed to him at the School, P.O. Box 101, Piscataway, New Jersey 08854.

“... raison d'être of cellular immunity is a surveillance system against mutations in multicellular organisms ...”

Table 1
Types of Immunotherapy

1. Passive — Historical — Transfusion
2. Adoptive — Transfer from One Patient to Another
 - A) White Blood Cells
 - B) Transfer Factor
 - C) Thymosin
 - D) Immune RNA
- 3) Active
 - A) Specific — Tumor Cell Vaccines
 - B) Nonspecific — Immune Adjuvant
BCG
 - C. Parvum
 - Levamisole

immune surveillance, but of the natural stimuli to halt lymphoproliferation. It has been shown that in some conditions associated with immunodeficiencies, the incidence of cancer is small. Finally, the majority of tumors in the immunodepressed are thought to be of viral rather than chemical etiology, therefore the defect may be a defect in immunity against infection instead of immunity against cellular mutations.

IMMUNOTHERAPY

Immunotherapy has been divided into a variety of types (Table 1). Passive immunotherapy is of purely historical importance and is based on the observation of tumor regression with transfusions. The two most common forms of immunotherapy utilized today are adoptive and active. In the former, immune memories are transferred from a donor to a recipient. This can be done by whole viable lymphocytes, transfer factor, thymosin and immune RNA. Active immunotherapy, on the other hand, is both specific and nonspecific. The former utilizes tumor cell vaccines, while the latter employs immune adjuvants such as BCG, C. Parvum and levamisole. Adoptive immunotherapy has rather specific disadvantages. Among these are the question of donor availability and donor selection. It is debatable that a human donor can ever yield an optimally reactive immunological extract. The ethical consideration surrounding the immunization of normal, healthy, volunteers against the tumors of cancer patients is overwhelming and should it be found that these donors are the only sources of useful anti-tumor extracts, the likelihood of clinical application of this technique is exceedingly poor. Finally, it is possible that the use of cured cancer patients as donors will in itself be immunosuppressive and lead to recurrence of their tumors.

TYPES OF IMMUNOTHERAPY

(A) **BCG and Cancer**—*Bacillus Calmette et Guérin* is a product of the progressive attenuation of *Mycobacterium bovis*, a vaccine utilized extensively in Europe to immunize patients against tuberculosis. It has been demonstrated to be an intense stimulant of host immunity. Animal studies have shown prevention of tumors both of the chemical and viral types, but treatment of growing tumors with systemic BCG has had very poor results. On the other hand, local inoculation with BCG into the tumor in animal models has had positive results. In human studies, the question of prevention has not been addressed directly, except for studies in which the incidence of leukemia in children immunized with BCG was shown to be less than in the general population.¹ However, a controversy surrounding the statistical techniques in these studies has evolved. BCG has been applied to a variety of human malignancies including melanoma, lung cancer, breast cancer and leukemia with some success,

especially in malignant melanoma.

(B) **C. Parvum**—*C. Parvum* is a heat-killed corynebacterium parvum. It is a general immune stimulant and has been demonstrated to be effective in the treatment of animal tumors. *C. Parvum* has been extensively studied by Israel *et al.* and applied to bronchogenic carcinoma, breast cancer, nonlymphomatous sarcomas and melanoma.^{2,3}

(C) **Levamisole**—Levamisole is an antihelminthic which does not stimulate immunity above normal levels in healthy subjects. It is most effective in the treatment of hematogenous metastases and as an adjuvant to cytoreductive therapy. The application of levamisole in breast cancer, leukemia and lung cancer has been described recently.

(D) **Other**—Thymosin, an extract of bovine thymus, is a pure T-cell stimulator. Early clinical trials have been reported. Transfer factor is an extract of human leukocytes which transfers the specific memories of the donor to the recipient. As a result of its lack of immunogenicity, it is a theoretically attractive form of immunotherapy. Clinical trials have yielded equivocal results. Immune RNA is an RNA rich nucleic extract derived from lymph after sensitization to specific antigens. It is different from transfer factor in that it is purported by its originators as capable of xenogenic transfer across species lines. Trials in human patients with melanoma, colon carcinoma and hypernephroma have been equivocal.

IMMUNOTHERAPEUTIC TRIALS

(A) **Malignant Melanoma**—A most dramatic clinical result of immunotherapy has been obtained in the treatment of malignant melanoma by Morton. These studies, since confirmed by many others, demonstrated that cutaneous lesions undergo complete regression following local BCG injection, provided the patient is immunocompetent as shown by a variety of immune parameters.⁴ It appears that the response is not simply inflammatory since 20 percent of patients develop concomitant regression of uninjected skin nodules. Approximately one-fifth of patients remain free of disease for long periods of time. Most, however, develop additional lesions and die from their systemic disease. Visceral metastases rarely respond to BCG immunotherapy.

Other immunotherapeutic agents also have been successful to some degree in malignant melanoma. These include the injection of vaccinia virus⁵ and topical dinitrochlorobenzene.⁶ Phytohemagglutinin (PHA) and *C. Parvum* also have been successfully utilized.^{7,8} It is important to remember, however, that while these forms of local immunotherapy provide a useful alternative palliative treatment for cutaneous lesions and stimulate host resistance, it is improbable that patients with disseminated melanoma ever will be cured of their disease with this type of therapy.

A trial of adjuvant immunotherapy following surgical resection for malignant melanoma with metastases to the regional lymph nodes also has been reported.⁹ Patients in the immunotherapy group received weekly intradermal BCG up to one year after resection and biweekly thereafter. These were compared to another group where surgical treatment alone was utilized. By life table analysis, the immunotherapy group had a statistically significant reduction in the probability of recurrence. However, this trial was not randomized and the immunotherapy group was a generally younger population. Whether or not this influenced the results is unclear and a strictly randomized perspective trial is presently being undertaken.¹⁰

(B) Lung Cancer—Application of immunotherapy to lung cancer has been stimulated by the very poor results achieved in this disease with conventional cytoreductive therapy. The study of greatest significance is that of McKneally *et al.*¹¹ in which intrapleural BCG was utilized in Stage I, II and III disease with three-year followup. The difference in survival and recurrence in the BCG treated group is statistically highly significant as compared to the control group in Stage I disease. No effect, however, was noted in Stages II and III patients. This study is probably the most dramatic demonstration of a significant effect of BCG as adjuvant therapy in human malignancy. In addition, the positive results in Stage I disease and lack of effect in patients with Stage II and III disease supports the contention that immunotherapy is most effective in patients with the smallest tumor burden.

Lung cancer also has been evaluated by the British Study Group utilizing levamisole.¹² The drug was given before and after operation and no other treatment was utilized in the absence of recurrence. There were few recurrences in the levamisole treated group (10 out of 57) as compared to the control group (20 out of 60), but these differences were not statistically significant. One important and significant result in the study was the smaller incidence of distant metastases in the levamisole group; this suggested its usefulness as an adjuvant to cytoreductive therapy in the prevention of hematogenous metastases. Yamamura *et al.* have studied the use of BCG cell wall skeletons in patients with lung cancer and compared it to an historical control group.¹³ They demonstrated improved survival in the C. Parvum group versus those who were treated by chemotherapy alone. The results are not statistically significant. A soluble tumor antigen vaccine and Freund's adjuvant have been utilized by Steward¹⁴ and by Takita and his group¹⁵ in separate studies in the treatment of lung cancer. The results have been equivocal.

(C) Breast Cancer—The history of the application of immunotherapy to breast cancer has included the control of local recurrences and distant metastases. Klein, Pardridge and Stjernsward all have reported a response to local injection with BCG and/or DNCB in patients with locally recurrent breast cancer.¹⁶ As with malignant melanoma, these results are not curative but simply provide an effective local treatment in patients with systemic disease where the management of the local recurrence is of prime importance.

In the most controversial study to date, Rojas *et al.*¹⁹ have applied levamisole to Stage III breast cancer in patients who were treated by radiation alone. They demonstrated a markedly significant difference between the levamisole treated group and the control group, both in the disease-free interval and survival. However, it has been pointed out correctly that, despite these remarkable results, the control group survival in this study was far less than the expected

survival in similarly staged patients in a variety of other studies. The question, therefore, has been raised as to patient selection in the control group and a repetition of the study in a randomized prospective manner has been undertaken recently. Israel *et al.*² have reported the application of C. Parvum to human breast cancer in conjunction with chemotherapy and demonstrated a slightly different survival in favor of the C. Parvum-treated group but these results have not been corroborated by others. Gutterman *et al.*²⁰ have compared the use of BCG in conjunction with chemotherapy and demonstrated superior survival in the BCG treated group.

(D) Colon Cancer—Little has been accomplished in the treatment of colon cancer with immunotherapy. In the most remarkable study to date, Mavligit *et al.*, from the M.D. Anderson Hospital, have compared survival in patients with Duke's C colorectal cancer treated by 5-Fluorouracil and BCG against BCG alone and both groups were compared to an historical control.²¹ In both treatment groups, there was significantly less recurrence and a longer disease-free interval in patients in the treatment groups. However, the use of an historical control has been criticized and this study is being repeated in a prospective randomized fashion. Falk *et al.*²² have employed intraperitoneal BCG, much the way McKneally reported the use of intrapleural BCG, and, although the possibility of its safe clinical use has been suggested, equivocal results have been achieved in a variety of intestinal tumors including colon cancer.

CONCLUSIONS

Despite the intense interest which has evolved in the immunotherapy of malignant disease during the last decade and the compelling logic of utilizing the host's inherent defense mechanisms to combat a devastating illness, enthusiasm for immunotherapy has been seriously eroded by the realization that this form of treatment has had little effect on established disease except in the few clinical situations cited above. In addition, as research into the basic immunobiology of cancer has expanded, a number of the initial hypotheses and observations have proved to be either highly questionable or false. The immune responses of the cancer patient, while demonstrable by a variety of *in vivo* and *in vitro* techniques, are relative phenomena not only in terms of potency but also in terms of the number of cancer cells which can be eradicated by modulation of immune mechanisms. Thus, except for palliative local management of recurrent disease in breast cancer and melanoma, it is now recognized that immunotherapy, at best, may become a useful adjuvant to conventional cytoreductive therapy. On the other hand, it is also true that this decade of intense interest in tumor immunology and immunotherapy has yielded an impressive base of data on the biology of cancer which undoubtedly will

"Little has been accomplished in the treatment of colon cancer with immunotherapy."

“Innovative applications of immunotherapy should be supported and continued despite the general pessimism which this report invokes.”

prove essential to the eventual understanding and, hopefully, cure of a variety of human malignancies.

As should be evident from the discussion of various immunotherapeutic agents and their application to common human cancers, the role of immunotherapy and especially its application in human trials must be reassessed. If immunotherapy is to be a useful clinical tool, it must be recognized as an essentially unproven form of treatment and the content of clinical trials must be designed rigorously in a prospective randomized fashion. Selection of patients, both for immunotherapy and control groups, necessitates adequate numbers of patients, exquisitely accurate diagnosis and staging and painstakingly vigorous statistical analysis. Historical controls, as well as a variety of other variables, must be assiduously avoided.

Innovative applications of immunotherapy, such as those cited above in lung cancer and breast cancer, should be supported and continued despite the general pessimism which this report invokes. Application of immunotherapy to a variety of malignancies whose outcome at the present time is so terribly bleak, such as carcinoma of the pancreas, stomach and colon would seem to be in order. Perhaps the generally negative tone of the last five years is essential to put the euphoria of an earlier time into perspective and help recognize that immunotherapy, as a clinical tool, is in its earliest stages. Still, it has not reached its full potential and improvement in immunotherapeutic agents, regimens, and applications remain very likely. There can be no question that immunotherapy is not the panacea which it once was thought to be. On the other hand, none of the other forms of therapy presently applied to human cancer can claim that role either. As such, the day still may come when immunotherapy combined with chemotherapy, surgery and radiation therapy will be able to claim a reliable, consistent and predictable ability to cure any number of human cancers.

SUMMARY

The clinical application of immunotherapy to human malignancy now has progressed to the point where a variety of cancers have been treated with various types of immunotherapy. While the results are generally equivocal, a few noteworthy exceptions exist. This, together with the generally less than spectacular results of conventional adjuvant therapy in human solid tumors, encourages the continued use of immunotherapy in prospective randomized clinical trials. In addition, immunotherapy is an outgrowth of basic research into tumor immunobiology and as such has increased markedly the basic understanding of the biology of human cancer.

REFERENCES

1. Davignon L, Lemonde P, Robillard P, Frappier A: BCG vaccination and leukemia mortality. *Lancet* 2:638, 1970.
2. Israel L, Edelstein R: Nonspecific immunostimulation with corynebacterium parvum in human cancer, in: *Immunological Aspects of Neoplasia*. Baltimore, Williams and Wilkins Company, 1975, pp. 485-504.
3. Israel L: Clinical results with corynebacteria, in G Mathe (ed): *Symposium on Cancer and Immunity*. Paris, Centre National de la Recherche Scientifique, 1972, pp. 486-487.
4. Morton DL, Goodnight JE: Clinical trials of immunotherapy: Present status. *Cancer* 42:2224-2233, 1978.
5. Hunter-Craig I, Newton KA, Westburg G, Lacey BW: Use of vaccinia virus in the treatment of metastatic malignant melanoma. *Br Med J* 2:512-515, 1970.
6. Malek-Mansour S: Remission of melanoma with DNCB treatment. *Lancet* 2:503-504, 1973.
7. Cheema AR, Hersh EM: Local tumor immunotherapy with *in vitro* autochthonous lymphocytes. *Cancer* 29:982-986, 1972.
8. Cunningham-Rundles WF, Hirschaut Y, Pinsky CM, Oettgen HF: Phase I trial of intralesional corynebacterium parvum. *Clin Res* 23:337A, 1975.
9. Eilber FR, Morton DL, Holmes EC, Sparks FC, Ramming KP: Adjuvant immunotherapy with BCG in treatment of regional lymph node metastases from malignant melanoma. *N Engl J Med* 294:237-240, 1976.
10. Filber FR, Townsend CM, Morton DL: Osteosarcoma: Results of treatment employing adjuvant immunotherapy. *Clin Orthop* 111:94-100, 1975.
11. McNeally MF, Maver C, Kausel HW: Regional immunotherapy of lung cancer with intrapleural BCG. *Lancet* i:377-379, 1976.
12. Amery W, Swierenga J, Gooszen H, Vanderschueren RG, Cosermans J, Louwagie A, Stam J, Veldhuizen RW, Lopes Cordozo E: Immunopotentiality with levamisole in resectable bronchogenic carcinoma: A double-blind controlled trial. *Br Med J* 3:461-464, 1975.
13. Yamamura Y, Sakatani M, Ogura T, Azuma I: Adjuvant immunotherapy of lung cancer with BCG cell wall skeleton (BCG-CWS). *Cancer* 43:1314-1319, 1979.
14. Stewart THM, Hollinshead AC, Harris JE, Belanger R, Crepeau A, Hooper GD, Sachs HJ, Klaassen DJ, Hirte W, Rapp E, Crook AF, Orizaga M, Sengar DPS, Raman S: Immunochemotherapy of lung cancer. *Am NY Acad Sci* 277:436, 1976.
15. Takita H, Takada M, Minowada J, Han T, Edgerton F, in WD Terry and D Windhorst (eds): *Immunotherapy of Cancer: Present Status of Trials in Man*. New York, Raven Press, 1978, pp. 217-223.
16. Klein E, Holtermann O, Milgram H, Case RW, Klein D, Rosner D, Djerassi E: Immunotherapy for accessible tumors utilizing delayed hypersensitivity reactions and separate components of the immune system. *Med Clin N Amer* 60:389-418, 1976.
17. Pardridge DH, Sparks FC, Wile AG, Morton DL: Intratumor injection of BCG for chest wall recurrences of breast carcinoma. *Proc Am Soc Clin Oncol* 18:326, 1977.
18. Stjernswärd J, Levin A: Delayed Hypersensitivity induced regression of human neoplasms. *Cancer* 28:628-640, 1971.
19. Rojas AF, Friestern JN, Michiewicz E, Glait H, Olivari AJ: Levamisole in advanced human breast cancer. *Lancet* i:211-215, 1976.
20. Gutterman JU, Mavligit GM, Burgess MA, Cardenas JO, Blumenschein GR, Gottlieb JA, McBride CM, McCredie KB, Bodey GP, Rodriguez V, Freireich EJ, Hersh EM: Immunotherapy of breast cancer, malignant melanoma, and acute leukemia with BCG: Prolongation of disease-free interval and survival. *Cancer Immunol Immunother* 1:99-107, 1976.
21. Mavligit GM, Burgess MA, Siebert GB, Jubert AV, McBride CM, Gehan EA, Gutterman JU, Khankhanian N, Speer JF, Martin RC, Copeland EM, Hersh EM: Prolongation of postoperative disease-free interval and survival in human colo-rectal cancer by BCG or BCG plus 5-fluorouracil. *Lancet* i:871-875, 1976.
22. Falk RE, Macgregor AB, Landi S, Ambus U, Langer B: Immunostimulation with intraperitoneally administered *Bacillus Calmette-Guerin* for advanced malignant tumors of the gastrointestinal tract. *Surg Gynecol Obstet* 142:363-368, 1976.

CASE REPORTS

Maternal Mortality in Pregnancies Complicated by Kyphoscoliosis*

MICHAEL KREITZER, M.D. and
MARGARET GREGORY, M.D., Trenton

Four cases of maternal death associated with kyphoscoliosis are reported. Obstetric management of pregnancy complicated by scoliosis is reviewed. The cases are of particular interest in light of Chapter 97, Laws of New Jersey 1978, which mandates screening for scoliosis by local school districts.

Hippocrates classified abnormal spinal curvature into kyphosis, scoliosis and lordosis. He also recognized the association between chest deformities and cardiorespiratory failure when he wrote "such persons as become hump-backed before puberty from asthma or cough, die."

Kyphoscoliosis is found in about one percent of the general population; and in 90 percent of these, the deformity is mild and requires no medical attention. The association of kyphoscoliosis and pregnancy is uncommon with a reported incidence of 1:1400 to 1:12000.³ Though both obstetric and cardiopulmonary complications are well recognized, kyphoscoliosis traditionally has not been thought of in connection with maternal mortality.

The passage of Assembly Bill No. 254, which became Chapter 97, Laws of New Jersey 1978, has focused attention in this State on the prevention of scoliosis. The purpose of the legislation was to prevent this deforming and disabling condition which occurs mainly in girls during their adolescent years.

The review of maternal deaths, which has been carried out jointly by the Maternal and Child Care Committee of the Medical Society of New Jersey and the Maternal-Child Health Program of the New Jersey State Department of Health, has disclosed four maternal deaths since 1974 in which kyphoscoliosis has been implicated as a complicating or contributory factor. These four cases may be summarized

as follows:

Case 1—A 17-year-old female gravida 1, para 0, was admitted to the labor and delivery suite at 35 to 36 weeks of gestation. She had a history of "spotting" one week previously and ruptured membranes for seven hours with irregular uterine contractions.

The patient was 4 ft. 6 in. tall, weighed 86 lbs. and was known to have kyphoscoliosis. Pelvimetry showed a deformed pelvis inadequate for delivery and a shoulder presentation. Chest x-ray disclosed severe kyphoscoliotic spinal curvature and poor inspirational volume, but the lungs appeared aerated and the heart was not decompensated.

Cesarean section was performed six hours after admission and an 1880 gm. living baby was delivered. One unit of blood was given preoperatively because of a hematocrit of 26 percent; 800cc of 5 percent dextrose solution also were infused. Surgery went smoothly and estimated blood loss was 250cc. Postoperatively the patient developed pulmonary edema, with severe pulmonary distress and a tachycardia of 180/min. There was no urinary output. She was treated with Lasix®, Digoxin® and intubation with ventilation. A second unit of blood was infused. The patient went into cardiac arrest and expired nine and a half hours after admission. Autopsy revealed bilateral atelectasis and pneumothorax.

*This study is from the New Jersey State Department of Health. The authors may be addressed at the New Jersey Department of Health, Maternal and Child Health Program, P.O. Box 1540, Trenton, N.J. 08625.

"The majority of maternal deaths are due to cardiorespiratory failure, while obstetric complications account for relatively few."

"... in kyphoscoliosis, the enlarging uterus encroaches progressively upon a nondistensible thorax during a period when maternal alveolar ventilation continues to increase."

Case 2—A 29-year-old female was dead on arrival at the emergency room. No history of antepartum care, and no information on gravidity, parity or estimated date of confinement could be obtained. The patient was 4 ft. 5 in. and weighed 85 lbs.

Autopsy revealed advanced intrauterine pregnancy with a "well-formed baby boy 18 inches in length." Severe kyphoscoliosis was noted. The left lung was small and undeveloped and both lungs were congested.

The final autopsy diagnosis was acute cardiorespiratory failure due to severe congenital kyphoscoliosis and advanced intrauterine pregnancy.

Case 3—A 26-year-old female, gravida 2, para 1, was admitted to the obstetrical service at 37-1/2 weeks of gestation. She had increasing dyspnea over the last month and was admitted "for chest x-ray and cesarean section in the near future." The patient was known to have severe scoliosis which required surgery at seven years of age. She was 4 ft. 8 in. tall and weighed 76 lbs. A previous pregnancy one year before had been terminated by cesarean section; postoperatively she had required respiratory assistance for two days.

On admission x-ray showed lung fields aerated and clear. One observer noted decreased breath sounds on the left. For four days the patient complained of continued shortness of breath, but respiratory distress was not observed. Four days after admission a cesarean section was performed and a 2552 gm. baby girl was delivered. Assisted ventilation was continued after surgery. Nineteen hours later the patient developed respiratory distress and shock. She was treated with Levaphed®, bicarbonate, Lasix® and Isuprel® but despite all attempts at therapy she died four hours later. No autopsy was performed.

Case 4—A 29-year-old female, gravida 2, para 1 was admitted to the obstetrical service at 28 to 29 weeks gestation because of the acute onset of epigastric pain and vomiting thought to be due to food poisoning. No history of prenatal care was obtainable. The patient was known to have kyphoscoliosis, was "almost 4 ft. tall" and weighed 96 pounds. She had had an uncomplicated pregnancy "years ago."

On admission examination confirmed pregnancy compatible with the dates above. Hemogram was within normal limits except for a leukocytosis of 13,000 with 89 polys and 2 stab cells. Potassium was 3.1 mEq/l and there was 2+ albuminuria and 3+ acetonuria. Subsequent biochemical determinations, urinalyses and cultures were within normal limits.

The patient was treated with intravenous fluids and Maalox® and Ampicillin® by mouth. The next day she felt better and was able to eat. Surgical and obstetrical consultations were obtained. On the third day she seemed well and had a bowel movement. The pain recurred and a 936 gm.

infant (apgar 2/4) was delivered. Postpartum the patient was treated with intravenous ampicillin and did well. On the fourth day leukocytosis persisted with a shift to the left. Potassium was low and supplementation was given. The patient was eating well. She had a bowel movement, but the next day she appeared distended. Flat plate of the abdomen showed a loop of small bowel distended with gas. There were no signs of obstruction. Later in the day the distension increased and clinical signs of obstruction appeared. An exploratory laparotomy was performed on the sixth day. A loop of small bowel had rotated and become gangrenous and perforated; this was removed.

Postoperatively the patient required respiratory assistance and was hypotensive. The scoliosis caused a problem with placement of the endotracheal tube and the nasogastric tube. Twice the patient extubated herself of both tubes. She remained hypotensive, became oliguric and developed a brady-arrhythmia. Insertion of a pacemaker was attempted but the procedure was very difficult due to the structural deformity. The patient expired on the eighth hospital day despite the efforts described. Intravenous fluids, antibiotics, Lasix® and Digoxin® also had been administered.

DISCUSSION

The problems of kyphoscoliosis in pregnancy are twofold—medical and obstetric, with the degree of handicap depending on the region of the vertebral column affected. In general, the higher the level of the primary curvature, the more important the medical aspect, which may result in disorders of normal cardiac and respiratory function. Conversely, the lower the primary curvature, the greater the obstetric problem which may lead to dystocia and malpresentation. Rarely are there severe pelvic deformities associated with thoracic disease.

The majority of maternal deaths are due to cardiorespiratory failure, while obstetric complications account for relatively few.³ A high primary curvature may result in distortion and fixation of the thoracic cage with compression of the thoracic viscera resulting in diminished lung volume, ranging from large areas of segmental or lobar collapse to single or multiple areas of focal collapse. This renders the lungs more susceptible to infection and emphysema.

In many forms of cardiorespiratory disease, progressive decompensation may not occur after the early third trimester. However, in kyphoscoliosis, the enlarging uterus encroaches progressively upon a nondistensible thorax during a period when maternal alveolar ventilation continues to increase.⁶ Therefore, the pregnant patient with kyphoscoliosis is at ever-increasing risk and may suffer cardiac decompensation at any time during the third trimester and in labor. When the pulmonary reserve is limited, as indicated by a vital capacity of less than 1000cc,

there is a great likelihood of heart failure, including possible maternal death.

The lower the spinal deformity, the more likely is pelvic compromise. With a deformity in the lumbar region the pelvic changes are abnormal forward rotation of the sacrum, flaring out of the ischial fossae, and inward turning ischial bones. These changes result in a decreased transverse diameter of the pelvic outlet. The approximation of the sternum and symphysis, and the encroachment of the lower ribs on the iliac crests, cause acute antelexion of the uterus resulting in increased patient discomfort and fetal malpresentation. Cesarean section is complicated because the lower segment is inaccessible.³ The rate of operative delivery (low forceps, mid forceps, cesarean section) exceeds 70 percent, and when cesarean section is indicated the inaccessibility of the lower segment makes the classical cesarean section the procedure of choice.

Phelan *et al.*⁷ make the following recommendations in the management of these patients:

1. When pregnancy is confirmed, obtain and review extensive cardiopulmonary function tests and arterial blood gas measurements.
2. Make frequent examinations during the last half of pregnancy with particular attention to cardiopulmonary status.
3. Obtain x-ray pelvimetry if pelvic inadequacy is suspected.
4. Permit a trial of labor unless cephalopelvic disproportion is anticipated.
5. Monitor the patient closely throughout labor with

frequent vital signs, arterial blood gas measurements, cardiac monitoring, central venous pressure measurement and fetal monitoring.

6. Provide supplemental oxygen and maintain the patient in the upright position during labor.

7. The use of anesthesia and analgesia require careful consideration; excessive narcotics should be avoided. There is no single regimen which may be considered best in pregnancy with severe kyphoscoliosis. Epidural anesthesia may be considered in spite of anticipated technical difficulties.⁷ General endotracheal anesthesia, however, may be the anesthesia of choice in patients with severe deformity, since it permits optimal operative positioning and assisted ventilation during surgery as well as postoperative pulmonary assistance if necessary.

REFERENCES

1. Chau W, Lee KH: Kyphosis complicating pregnancy. *J Obstet Gynaecol Br Common W* 77: 1098-1102, 1970.
2. Dugan RJ, Black ME: Kyphoscoliosis and pregnancy. *Am J Obstet Gynecol* 73:89-93, 1957.
3. Jones DH: Kyphoscoliosis complicating pregnancy. *Lancet* 1:517-519, 1964.
4. Mendelson CL: Pregnancy and kyphoscoliotic heart disease. *Am J Obstet Gynecol* 56:457-467, 1948.
5. Bergofsky EH, Turino Gm, Fishman AP: Cardiorespiratory failure in kyphoscoliosis. *Med* 38:263-317, 1959.
6. Carlson D, Engleman DR, Bart AJ: Epidural anesthesia for cesarean section in kyphoscoliosis. *Anesth Analg* 57:125-128, 1978.
7. Phelan JP, Dainer MJ, Cowherd DW: Pregnancy complicated by thoracolumbar scoliosis. *South Med J* 71:76-78, 1978.

Transurethral Resection in a Two-Year-Old Boy*

PETER C. BOORJIAN, M.D., Montclair

A two-year-old male developed an obstructive uropathy. The cause, diagnosis and treatment are discussed.

Posterior urethral polyps are an uncommon cause of obstructive uropathy, hematuria, and infection in young boys. A total of 48 cases have been described in the literature.¹

CASE REPORT

A two-year-old male with acute urinary retention was brought to the emergency room by his mother. There was a three-week history of blood spots noted on the child's underwear and a history of dysuria one day prior to admission. The child had been continent of both urine and stool; there was no prior history of urologic disease including urinary infections.

Physical examination revealed an anxious two-year-old child in acute distress secondary to urinary retention. His abdomen was distended and the bladder was easily palpated at the level of the umbilicus. No flank tenderness was elicited; the external genitalia were those of a normal male with the exception of mild meatal stenosis. Complete blood count, urine culture, blood urea nitrogen and serum creatinine were within normal limits. However, a urinalysis demonstrated red blood cells. Catheterization produced a 300 cc residual urine. A diagnosis of retention secondary to meatal stenosis was made.

The child was taken to the operating room where a meatotomy and voiding cystourethrogram were performed. A posterior urethral filling defect extending into the bladder

neck was noted (Figure 1). Cystourethroscopy with an 8F pediatric cystoscope revealed a large stalked polyp, which originated from the verumontanum and extended through the bladder neck. Transurethral resection using an infant resectoscope was performed; a pediatric feeding tube was passed per urethrum and connected to straight drainage. The urine was clear, and the tube was removed 24 hours after surgery. Spontaneous voiding occurred and the child was discharged with sulfisoxazole suspension prescribed for one week. A pathologic tissue diagnosis of "hyalinized fibrous polyp" was reported.

DISCUSSION

The diagnosis of posterior urethral polyp can be made by voiding cystourethrography and confirmed by cystoscopy. Intravenous pyelography easily can mask such a polyp by the density of contrast medium at the bladder neck, so it should not be used alone to evaluate the posterior urethra. A differential diagnosis of non-opaque posterior urethral filling defects includes: ectopic ureteral insertion, posterior urethral valves, non-opaque stones, Cowper's duct cyst, urethral diverticulum, and hypertrophy of the verumontanum.

Although symptoms of obstruction, hematuria, and infection can be explained on the basis of meatal stenosis and/or meatitis, as noted in this patient's initial presentation, void-

*This report is from the Mountainside Hospital in Montclair, Dr. Boorjian may be addressed at 123 Highland Avenue, Glen Ridge, N.J. 07028.



Cystogram demonstrating bladder neck polyp.

ing cystourethrography is recommended to determine the correct diagnosis.

In 1973, DeWolf and Fraley reported the transurethral resection of a posterior urethral polyp via perineal urethrostomy in a three-week-old newborn.² The transurethral technique is favored over open surgical removal by prostatotomy since there is minimal risk to the bladder neck and ejaculatory ducts with a more accurate excision.

SUMMARY

Urinary retention in young males often is associated with mechanical obstruction due to congenital anomalies. Herein is reported a case of retention secondary to a posterior urethral polyp, with recommendations for diagnosis and treatment.

REFERENCES

1. Kearney GP, Lebowetz RL, Retik AB: Obstructing polyps of the posterior urethra in boys—embryology and management. *J Urol* 122:802, 1979.
2. DeWolf WC, Fraley EE: Congenital urethral polyps in the infant: Case report and review of the literature. *J Urol* 109:515, 1973.

Multicentric Endobronchial Granular Cell Myoblastoma*

KANTA DAVESSAR, M.D., WAYNE FARMER, M.D.,
STANLEY BECKER, M.D., Freehold

Granular cell myoblastoma (GCM) of the tracheobronchial tree is a rare tumor. In some of the reported cases multiple organ involvement has been present. Multicentric lesions of the major airways are extremely rare. A case of multiple endobronchial GCM is added to the already reported three cases in the world literature. Clinical features and histogenesis are discussed.

Granular cell myoblastoma is an uncommon tumor of neurogenic origin. It most often is encountered in the skin, tongue or larynx.^{9,10,15} Less frequently it involves the breast, bile ducts, vagina and thyroid.^{11,13,14} Granular cell myoblastoma of the tracheobronchial tree represents less than two percent of all myoblastomas.^{8,14} Multiple tumors are reported to occur in 20 percent of these cases. There may be involvement of multiple organ systems or multiple tumors in one organ may occur. Multicentric involvement of the major airways is extremely rare and only three cases have been described in the world literature. Because of the rarity of the lesion, a case of multiple endobronchial granular cell myoblastoma is reported.

CASE REPORT

A 39-year-old female was admitted with the complaint of cough and blood-tinged expectoration of two-weeks duration. This was accompanied also by sharp chest pain aggravated by deep breathing. Arterial blood gases revealed a minimal degree of hypoxemia. X-ray of the chest showed multiple linear densities in the left upper lung (Figure 1). A diagnosis of questionable malignancy or granulomatous disease was made. Bronchoscopic examination revealed a plaque-like lesion about one cm in maximum diameter in the postero-lateral wall of the left main stem bronchus and white granular lesions in the anterior segment of the left upper lobe bronchus (Figure 2). Multiple biopsies were taken. Micro-

scopic examination of both the lesions showed groups and sheets of rounded or polyhedral cells (Figure 3). The cells had pink granular cytoplasm with uniform round to ovoid nuclei (Figure 4). The overlying respiratory epithelium revealed pseudoepitheliomatous hyperplasia with squamous metaplasia bearing a resemblance to squamous cell carcinoma (Figure 5). A differential diagnosis of squamous cell carcinoma was considered. However, on closer examination the true nature of this lesion was obvious. No further treatment was given and the patient is being observed.

DISCUSSION

Granular cell myoblastoma was first described under the name of myoblastenmyom by Abrikossoff¹ in 1926. He believed it resulted from a degenerative/regenerative process of striated muscle following inflammation or trauma. The myogenic theory was accepted for a number of years thereafter, but controversy appeared as to whether it was a neoplasm which arose from adult or embryonic muscle tissue or whether it evolved as a non-neoplastic degenerative process. In 1926 Fisher and Wechsler, using electron microscopic and Wallerian degeneration studies, demonstrated a similarity between the granular cell myoblastoma cell and the Schwann cell.⁵ This finding was supported further by

*This study is from the Freehold Area Hospital, Rt. 537, Freehold, New Jersey 07728. Correspondence may be addressed to Dr. Becker at the Hospital.

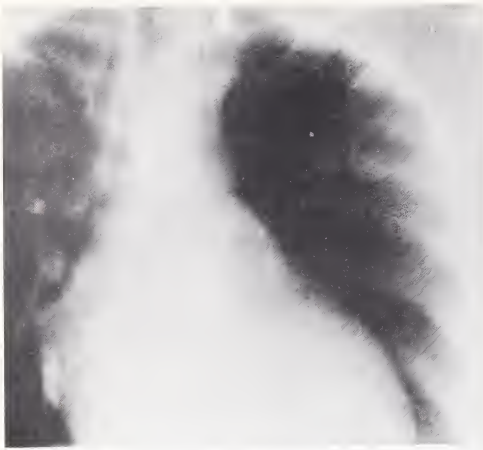


Figure 1—X-ray of chest showing multiple linear densities in the left upper lung fields.

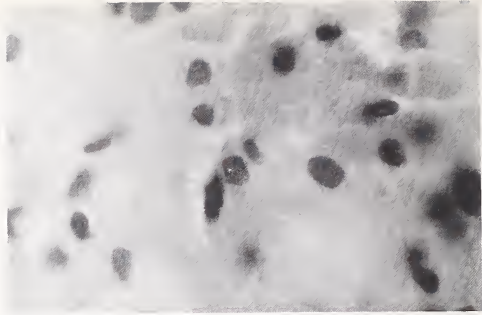


Figure 4—Cells having pink granular cytoplasm and uniform round to ovoid nuclei (H & E x 400).

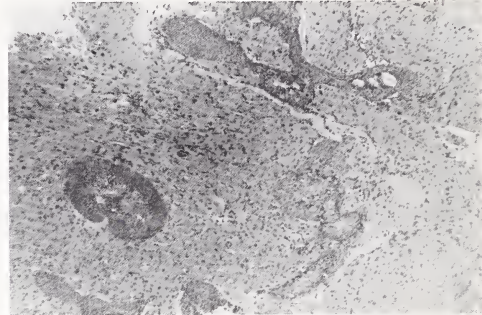


Figure 5—Pseudoepitheliomatous hyperplasia and squamous metaplasia of the overlying epithelium (H & E x 100).

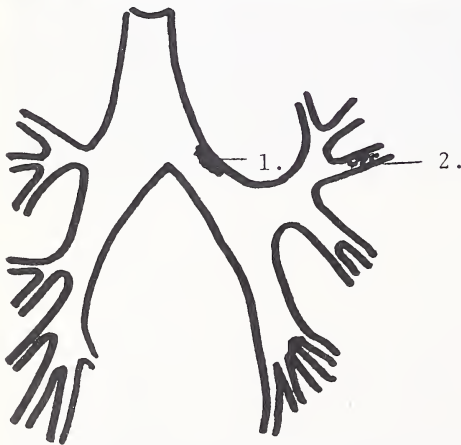


Figure 2—Diagrammatic representation of the lesion—(1) lesion in the left main bronchus, (2) lesion in the left anterior segmental bronchus.

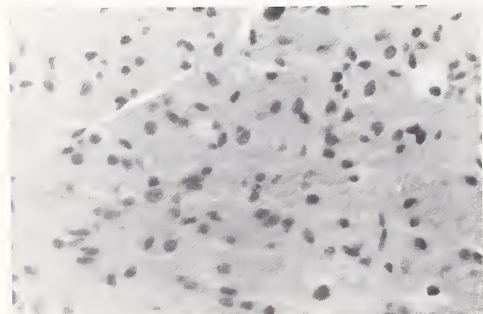


Figure 3—Groups and sheets of rounded or polyhedral cells (H & E x 100).

Moscovic and Azar⁷ and Mansour,⁶ *et al*, and is the most accepted view.

Review of the world literature indicates that there have

been 47 cases of endobronchial granular cell tumor reported. This lesion tends to originate in the walls of large bronchi especially near the site of bifurcation.³ Thirteen out of forty-seven patients reported to date have had multiple lesions. Involvement of lung with other organ systems was seen in ten cases (tongue in one, esophagus in three and skin in six). In three patients, the tumor had a multicentric origin in the endobronchial tree. The clinical and pathological features of these cases are shown in Table I.

The gross appearance of these tumors varies between sessile or pedunculated polypoid growths and plaque-like thickening of the mucosa several millimeters to seven cms in size. The histological appearance is very characteristic and uniform. The lesion is composed of groups and sheets of polyhedral cells having pale pink granular cytoplasm with PAS positive diastase resistant granules. The nuclei are small, ovoid and uniform in appearance. More than 50 percent of the cases show squamous metaplasia of the overlying mucosa and, in about 40 percent, the lesion was seen to extend through the entire thickness of the bronchial wall.¹⁰ Although the tumor is not well demarcated and infiltrates into the underlying muscular tissue, these lesions are always benign and no case of distant metastasis has been reported. In only one case was there infiltration of the adjoining lung parenchyma.¹⁰ The squamous metaplasia in this lesion must not be mistaken for well-differentiated squamous cell carcinoma.

The most common presenting symptoms are persistent cough, expectoration or hemoptysis. Pleuritis may be indicated by chest pain and signs and symptoms of bronchial obstruction may be present. X-ray examination of the chest

Table 1
Clinical and Pathological Features of Reported Cases

Author and Year	Age and Sex	Location	Clinical presentation
1. DePaola <i>et al.</i> , 1961	41 yr. M.	1. Left main bronchus 2. Lower lobe bronchus 3. Post. basal segment bronchus 4. Upper lobe bronchus near lingular branchus	Cough with expectoration and weight loss
2. Archer <i>et al.</i> , 1963	56 yr. F.	Distal trachea and both main branchi.	Cough and chest pain
3. Benson and Chapel, 1966	22 yr. F.	1. Trachea 2. Carina 3. Rt. branchus 4. Post. basal bronchus lower lobe, left lung 5. Ant. basal bronchus 6. Lateral basal bronchus	Episodes of pneumonia
4. Davessar <i>et al.</i> , 1979	39 yr. F.	1. Left main bronchus 2. Ant. segmental bronchus of left upper lobe.	Caugh with blood-tinged expectoration

usually reveals diffuse pulmonary infiltrates and atelectasis with a variable degree of bronchial lumen occlusion. Bronchoscopic examination aids in the diagnosis, although differentiation from adenoma and carcinoma can be made only by microscopic examination.

The treatment depends upon the location and size of the tumor and the changes in the bronchi and lung parenchyma distal to the site of involvement. Endoscopic resection usually is not advocated because of the submucosal location of the tumor and the potential for recurrence. When the patient first presents there is a variable degree of atelectasis and inflammation of the lung parenchyma secondary to the bronchial obstruction which these tumors frequently produce. In such cases bronchotomy with segmental resection and/or lobectomy has been the treatment of choice. Recent studies have advocated the use of CO₂ laser treatment for small proximal endobronchial granular cell myblastomas.³ Further evaluation of this form of therapy is still awaited.

SUMMARY

A multicentric endobronchial granular cell myblastoma was identified in a 39-year-old female. This case has been added to the three cases already described in the world literature. The patient's symptoms included sharp chest pain aggravated by deep breathing. Bronchoscopy showed plaque or white granular lesions in the left main stem and upper lobe bronchus. Biopsies showed granular cell myblastoma with pseudoepitheliomatous hyperplasia of the overlying epithelium. This should not be mistaken for squamous cell carcinoma. The patient was treated with CO₂ laser and is asymptomatic three months after treatment.**

**Personal communication from Dr. Albert H. Andrews, Jr., Chicago, Illinois.

“Review of the world literature indicates that there have been 47 cases of endobronchial granular cell tumor reported.”

REFERENCES

1. Abrikosoff A: Ueber myome, ausgehand von der quergestreiften willkürlichen muskulatur. *Virchow's Arch Pathol Anat* 260:215-233, 1926.
2. Benson WR: Granular cell tumors (myblastomas) of the tracheobronchial tree. *J Thorac Cardiovasc Surg* 52:17-30, 1966.
3. Daniel GS: Multiple granular cell tumors of the bronchii—treatment with laser. *Am Rev Resp Dis* 120:193-196, 1979.
4. DePaola D, Medeiros JAC, Rocha G, *et al*: Myoblastoma multiple di bronquio: Relata a un caso con pneumonectomia. *Rec Bras Cir* 41:197-202, 1961.
5. Fisher ER, Wechsler H: Granular cell myblastoma a misnomer: Electron microscopic and histochemical evidence concerning its Schwann cell derivation and nature (granular cell schwannoma). *Cancer* 15:936-954, 1962.
6. Mansour KA, Hatcher CR, Haun CL: Benign tumors of the esophagus: Experience with 20 cases. *So Med J* 70:461-464, 1977.
7. Moscovic EA, Azar HA: Multiple granular cell tumors (myblastoma): Case report with electron microscopic observations and review of the literature. *Cancer* 20:2032-2046, 1961.
8. Murphy GH, Dockerty MS, Broders C: Myoblastoma. *Am J Path* 25:1157-1182, 1949.
9. O'Connell DJ, MacMahon H, De Meester TR: Multicentric tracheobronchial and esophageal granular cell myblastoma. *Thorax* 33:596-602, 1978.
10. Oparah SS Subramanian VA: Granular cell myblastoma of the bronchus: Report of two cases and review of the literature. *Ann Thorac Surg* 22:199-202, 1976.
11. Ostermiller WE, Comer TP, Barker WL: Endobronchial granular cell myblastoma: A report of three cases and review of the literature. *Ann Thorac Surg* 9:143-148, 1970.
12. Roger C: Multicentric endobronchial myblastoma. *Arch Otolaryngol* 82:652-655, 1965.
13. Serper SJ, Todd D, Branch H: Cholecystitis due to granular cell myblastoma of the cystic duct. *Am J Diges Dis* 5:824-826, 1960.
14. Umansky C, Bullock WK: Granular cell myblastoma of the breast. *Ann Surg* 168:810-813, 1968.
15. Vance SF, Hudson RP Jr: Granular cell myblastoma: Clinicopathological study of 42 patients. *Am J Clin Path* 52:208-215, 1969.

“The commonest presenting symptoms are persistent cough, expectoration or hemoptysis.”

The History of My Stroke

GERALD E. MUEHSAM, M.D., Short Hills*

Seven years ago, in September 1973, I had a stroke which left me speechless and without any power in my left arm and leg. I had no speech at all for the first six months. However, my speech came back gradually and I am now talking; two years ago it was a difficult situation. It is the story of my aphasia that you will see and that I conquered in about five years.

I am not practicing any more, but it is interesting to recount the development of my recovery from aphasia and how I got where I am.

About ten years ago, headaches were a frequent problem of mine and I took Empirin® for them. The headaches were in the morning and I took the aspirin when I got up, at 6:30 a.m. Then I took my two dogs into the reservation and by the time I came home, the headaches had disappeared. I ran two or three miles every day, and the dogs enjoyed it very much. So did I. Once in a while, the headache came back in the afternoon, when I was in the office, and I took some medication for it and the headache disappeared about thirty minutes later. However, two or three times a month, they did not disappear, and I struggled to maintain my balance, and came home earlier than usual.

While vacationing on Chappaquiddick in 1973, I had a headache that lasted many hours, but instead of lying down, I ran two miles with the dogs. Then the headache got worse, and I went to the bedroom and passed out. I don't know why, but I was afraid that something was wrong with me, and I was scared to see a physician. In retrospect, it was very silly of me because an operation to side-shunt the clot was available in 1973.

I returned home at the end of August. I went to a tennis-dinner meeting on September 26, 1973 and won a trophy for best tennis player. Later that afternoon I took sick, and came home, but nevertheless dressed myself in some formal clothes and attended the banquet where the trophy was given to me. Afterwards I went home and went to bed right away, but the headache did not disappear.

The next morning I took two Empirin® and took the dogs for a walk in the reservation, but my headache did not disappear. I came home at 7:15 a.m. and showered and shaved. I had only coffee for breakfast, because my headache was with me all the time. Usually it disappeared after taking something, but not that morning.

I went to the telephone at 9:00 a.m. and rang the number of an ophthalmologist that I know. He was kind enough to see me right away. I drove to his office and consulted him.

He told me that nothing was wrong with my glasses or the back of my eyes, because I was suspicious that my eyes were at fault. I knew something was wrong, but I did not know where or what.

Then I consulted a colleague who examined me thoroughly, and told me that he did not find anything wrong with me. So I went to the hospital and made rounds, by which time I did not feel well at all, but the rounds came first. A colleague of mine stopped me in the hall to ask me some questions about his patient, but I did not answer them because I was anxious to finish rounds. Usually it was the other way around, and I would be glad to answer all questions in detail, but I was bushed and made my rounds very quickly. At 11:00 a.m. the rounds were done.

I think I felt worse then and my vision definitely did worsen. The thing to do was to go home, and I drove home very carefully, because my coordination was worse, and the drive home was a definite trouble for me. I came home at 11:30 a.m. and my wife and children were out. The children were at school and my wife was at some store to buy something. I went upstairs. I had trouble maneuvering the steps, and had difficulties with my tie. I finally got it off, but my pants and shoes I did not take off. I went to bed immediately. I had a headache, vision difficulties, and a strange sensation in my left arm. The legs were all right so far. My wife came home at 12:00 noon, and she was amazed to find me in bed, fully dressed but no tie.

She called the doctor right away, and he told her to bring me to the hospital immediately. We went in her car, and took the fastest way to the hospital. My wife left me in the emergency room and I took the elevator upstairs to the room to which I was assigned. Then it happened. I was lame on the left side of my body the minute I came upstairs, and I had trouble speaking. I did not know of anything for many days.

The doctors came running all the time, and internists, cardiologists and neurologists attended me in my plight. On September 27, 1973, the day of admission to the hospital, an angiogram was performed on the left side first because I am righthanded and was having trouble talking. The findings were very interesting. The right hemisphere was blocked and the right internal carotid artery was blocked by a congenital stenosis, but the left internal carotid artery was perfectly

*Dr. Muehsam is a board certified internist/cardiologist and a fellow of the American College of Physicians. He was on the attending staff at the Hospital Center at Orange. He may be addressed at 18 East Hartshorn Drive, Short Hills, NJ 07078.

clear in its dimension and had no blockage at all. You wonder where the aphasia came from, and I will explain it to you. In my childhood it was not usual to eat or otherwise have a spoon or knife in my left hand, but I was changed to the right hand many years ago, and did not know it at all. When the aphasia proceeded, and I was not able to talk, it was obvious to the doctors that I was changed around. I am certain that the reason my stroke was not fatal was because I went running in the reservation for four years and my cardiovascular system was otherwise in excellent shape.

My state of health did not get better for many days and weeks, and I want to tell you that I lost hope for myself ever to speak again. I had physiotherapy every day while I was in the hospital, and sometimes twice a day. But my speech did not return at all and I must say that it was very difficult to manage.

The anniversary of my marriage was on September 29, and I had bought my wife a present and hidden it in the office. But to understand my speech was impossible. After a couple of weeks, it took me thirty minutes to communicate by nodding that I had bought her an anniversary present and hidden it in the office. She searched for it and eventually found it and brought it to the hospital.

I remember very well when I talked for the first time. It was about four weeks after the stroke. My speech therapist came twice a day, but I did not talk. However, that afternoon I talked for ten seconds and I felt satisfied with the progress.

A few days after the stroke, a physiotherapist and speech therapist came to me twice a day. About three weeks later I went to the Rehabilitation Department itself and I had occupational therapy, speech and physiotherapy once a day.

Eventually, after eight weeks, I came home. It was Thanksgiving Day, but I hardly made it because I was so tired after the trip. I went upstairs very slowly, and went to bed right away.

This is the story of my rehabilitation and it took many months to recover. My left leg and arm are crippled but I am used to it. I used to go to the hospital several days a week for physio- and speech therapy and my wife or some friends would drive me.

After a while, in 1974, I received a permit to drive myself (after being road tested) and I did not need any assistance. However, in driving, the directional signals were controlled from the left side. Being unable to use the signals because of the left side paralysis, I had a special harness attached to the signals so that they could be used on the right side. The power in my left side has never returned.

I had speech therapy and occupational therapy three times a week. At home I exercised in the mornings. I progressed with my speech therapy very much, and had it for five years. The results were excellent. I am talking very well now and I drive the car and go to the hospital for conferences. However, I do not practice medicine anymore and I miss it very much.

I have many friends in the hospital and elsewhere, and see them frequently. Many people think that I am alright because in the morning and in the afternoon after a nap I speak so well. During the afternoon I am tired and do not speak so well, but I sleep in the afternoon and by the time I get up I am refreshed. It is too bad, but then I am tired again at 10:00 p.m. and go to bed and sleep for eight hours. Eight hours is the minimum time that I must rest, because otherwise I am sleepy in the morning also. I used to get five to six hours of sleep when I was in practice but not anymore.

I attend various lectures, seminars and discussions at the

hospital and enjoy them a great deal. I have taken some art classes and went to the University in the fall of 1979 to take a lecture class in English literature. My wife and I go to the city and have a meal or attend a concert or visit friends.

Speech therapy was begun when I had my stroke, and it lasted for five years. At first I also had difficulty comprehending both the written and spoken word. After a while, my comprehension improved. About two years later, in 1975, I was able to speak slowly but not yet in complete sentences. That came later during my subsequent recovery.

It might be interesting to note that I was born in Germany and migrated to the United States before the second world war. My mother tongue was German and I did not start to learn English until I was 14 years old.

My speech therapy included homework and I completed it, but very slowly. However, the names of individuals and arithmetic are very difficult even now, and I have trouble remembering proper names. However, it is improving steadily. I keep a list of names and consult it when I have trouble. Arithmetic is another problem and I am afraid that I will not conquer it. I have a calculator at home and I use it to pay bills and to calculate my monthly statements.

In the beginning my speech therapist was very aware of my difficulties and guided me along the best way possible. Particularly, the difficulties with pronouns and adjectives disappeared by the fifth year after the stroke. I never had any trouble spelling difficult words. My speech is excellent now. Several hours of talking and I am exhausted. I have to sleep for a while and relax but after a while my speech comes back again. It is strange that it affects the speech center and nobody knows how and why it works.

Finally, I must say that it has been a very difficult journey, but I have conquered it moderately well. I have to say this to everyone who has a stroke—don't give up the ship. Try to fight it and the results will be rewarding. I had been depressed and morose, but I have recovered from it. One must consider the age factor. I was 49 when it happened. This gave me a far greater chance of recovery than it would had it happened at the age of 69.

The progress in my awareness of my feelings was very slow after my stroke, but during the following years it became much better. During the first four years I had difficulties conversing and talking like everyone else, but during the last two years it has been much better. The exhaustion comes on me like a flash and I am so fatigued that I must rest. However, the need for rest was very much more severe two or three years ago than it is today. Now I hold a conversation for three or four hours and I am not tired, but three years ago, I was tired when I started it. Also, I feel much happier now than two or three years ago. Then I could not remember a thought which I had had for one minute, but it is much better today. My memory is also very much better now than two or three years ago. My speech is getting better all the time and I don't understand why. I have experienced many stroke cases but in every case they did not progress as far as I have.

My family was very kind to me and when I could not speak they would ask questions of me to which I would nod a reply. However, when I sat down to dinner with my children, I usually shut up and did not talk, because it was impossible to interrupt them. But my wife is patient with me and communication is no longer a problem. In the evenings I sit in the den and occasionally my wife will come along, but usually she sits downstairs reading. It was very different before my stroke when my wife and children were much younger and

gathered around me for games or things to do. Lately my wife and children are much better and they talk to me.

After I had the stroke my anger and hostility were very great and I flew off the handle a lot. It is better today and my anger is not so bad, but when something unpleasant happens my anger still flares up. But it is very rare now and I am controlling it much better.

Some of my friends have disappeared since my stroke and I feel that it is their loss and I do not miss them. But my good friends are with me and we visit them or invite them to our house. With strangers I am very confident. I talk much better with people whom I do not know. It is marvellous to meet somebody who is a stranger and not suffer or avoid them. However, with my fellow physicians it was very difficult to speak in the beginning and I had trouble making them understand me. In former times, everybody in the hospital was gracious to me, but after the stroke many people avoided me. Whether it was out of embarrassment or fear, it was nevertheless very embarrassing to me, but I got over it. When I go to the hospital now, most people talk to me and I am glad of it. Two years ago, I was afraid to go to the hospital, but not anymore. In fact, I talk in the conferences when I have something to say and it is not at all difficult anymore. I was a successful practitioner, and then I was nothing anymore, and it hurt me very much, but I got over it.

CONCLUSION

When a person is paralyzed with a stroke or anything else the greatest effort must be made to rehabilitate the individual. It took me about five years to converse and speak properly, but I managed it and my speech is now relatively intact. Of course, some problems remain, such as abstract thinking and arithmetic, but I manage very well despite my difficulties. Although I am not practicing medicine any more, I keep busy with all sorts of other things, and my life is full of joy.

Comment by Stuart D. Cook, M.D., Professor and Chairman, Department of Neurosciences, New Jersey Medical School, CMDNJ.

I have read the description of a personal stroke experience by an unfortunate young physician. The story is that of a dominant right hemisphere infarct, presumably due to narrowing or occlusion of the right internal carotid artery. The author states this was due to congenital stenosis, however it is difficult from the description presented to exclude acquired atherosclerosis narrowing of this vessel. The patient apparently had headaches for several years prior to his ictus. While headaches in this age group are more commonly due to migraine or tension, several features of these headaches suggested a more ominous diagnosis, i.e., early morning onset and a paroxysmal loss of consciousness. Prior to angiography, an intracerebral mass lesion would have been high on the differential list. Headaches also can be associated with anterior circulation problems as in this case.

The patient obviously had severe neurologic deficits initially and has had a persistent left hemiparesis. His aphasia gradually cleared over two years which is not an unusual time course for improvement of aphasia. He has residual dysnomia and dyscalculia suggesting posterior parietal-temporal dysfunction.

Comment by Henry R. Liss, M.D., Clinical Associate Professor of Surgery (Neurosurgery), Rutgers Medical School, CMDNJ.

I believe that this paper is not only suitable for publication but an important message to our readers.

The author makes no attempt to define the background causes of his headaches nor is there reason to suspect that they were an indication of potential stroke liability. He insinuates that the availability of "an operation to side-shunt the clot was available in 1973" might have spared him the agonies he went through but does not tie that statement in with the arteriographic findings on the day of his admission to the hospital with aphasia and hemiplegia. It is left to us to infer that the congenital stenosis of the right internal carotid artery might have been opened or bypassed to prevent the stroke. If there were true stenosis, the two vertebral arteries and the left common carotid artery via the Circle of Willis had been sufficient to support the needs of the right hemisphere. The writer does not offer an explanation for the sudden insufficiency of circulation. Nor can he offer any explanation of his pre-stroke headaches. He does not tell us whether he is still having headaches.

Medical explanations aside, the lessons to be learned from this important paper are the subjective feelings of the patient which are so well presented and the problems he encounters with his peers and family. The feelings of isolation, the hopelessness, anger and frustration, as well as the ever-present fatigue with effort are beautifully presented. These feelings and insights should be a part of the professional understanding and empathy of every physician who comes in contact with a stroke victim. The time it takes for the stroke patient to recover sufficiently to be independent, of course, varies from patient to patient but the word here is courage and patience, both on the part of the patient, the family and the physician. Two years is a minimum for a stroke patient to reach a reasonable plateau but insidious slow improvement can be expected for as long as five years before the patient hits a final plateau. Most physicians are not aware of the time involved and give up too easily.

The author makes an important point when he states "at first I also had difficulty comprehending both the written and the spoken word. After a while, my comprehension improved." All too often, physicians forget that stroke patients, severe head injury patients and brain tumor patients cannot comprehend rapid speech or shifting from subject to subject. On their hurried visits to the patient, family and physicians alike are too impatient to understand the need of the person being addressed. Often, comprehension and speaking recover at uneven rates. Families must be taught how to deal with the brain-injured individual and cannot be left to their own frustrations or they, too, will avoid the patient as the author infers. He acknowledges his temper flare-ups but makes no mention of the usual emotional lability of the brain-injured patient. He points out how "some of my friends have disappeared since my stroke," bringing up a very important point of how physicians often avoid their patients with communication problems or brain damage. It is all too true, as the author writes, "in former times, everybody in the hospital was gracious to me but after the stroke, many people avoided me. Whether it was out of embarrassment or fear, it was nevertheless very embarrassing to me, but I got over it." The lack of sensitivity on the part of hospital personnel could be overcome with instruction at all levels of care from the physician and nurse down to the aides and cleaning personnel. The author was indeed fortunate to have the personality which enabled him to persist in his retraining and the finances to afford five years of speech and other therapy. His experience has a great deal to offer all medical personnel. We

must learn not to abandon the brain-damaged individual and to continue the rehabilitation process for a number of years rather than just a few months, if the patient is to be afforded the opportunity to become independent and to regain self-respect. Too little time has been spent in consideration of the

restoration of the brain-damaged adult to a respectable place in society. The emphasis has been on the handicapped child or the physically-damaged individual and not enough effort has been put forth on behalf of the adult brain-damaged person of whatever age group.

Housing Application—Meadowlands Hilton Annual Meeting, MSNJ—May 15-19, 1981

Please Reserve: _____ Single _____ Double _____ Twin _____ Suite _____

Arrival: (date) _____ at (time) _____

Departure: (date) _____ at (time) _____

Name _____

Address _____

City _____ State _____ Zip Code _____

If double or twin name of person joining _____

Single: \$56

Twin: \$67

Double: \$67

Suite: \$150 and up

If range of rates is offered and rate requested is not available, the next available rate will be assigned. Reservations must be received no later than two (2) weeks prior to the opening date of your meeting and will be held until 6 p.m. on day of arrival unless otherwise specified.

(New Jersey Sales Tax - 5%)

Complete and mail this application to: Front Office Manager
The Meadowlands Hilton
Two Harmon Plaza
Secaucus, New Jersey 07094

Double Tachycardias

EDWIN L. ROTHFELD, M.D., Newark

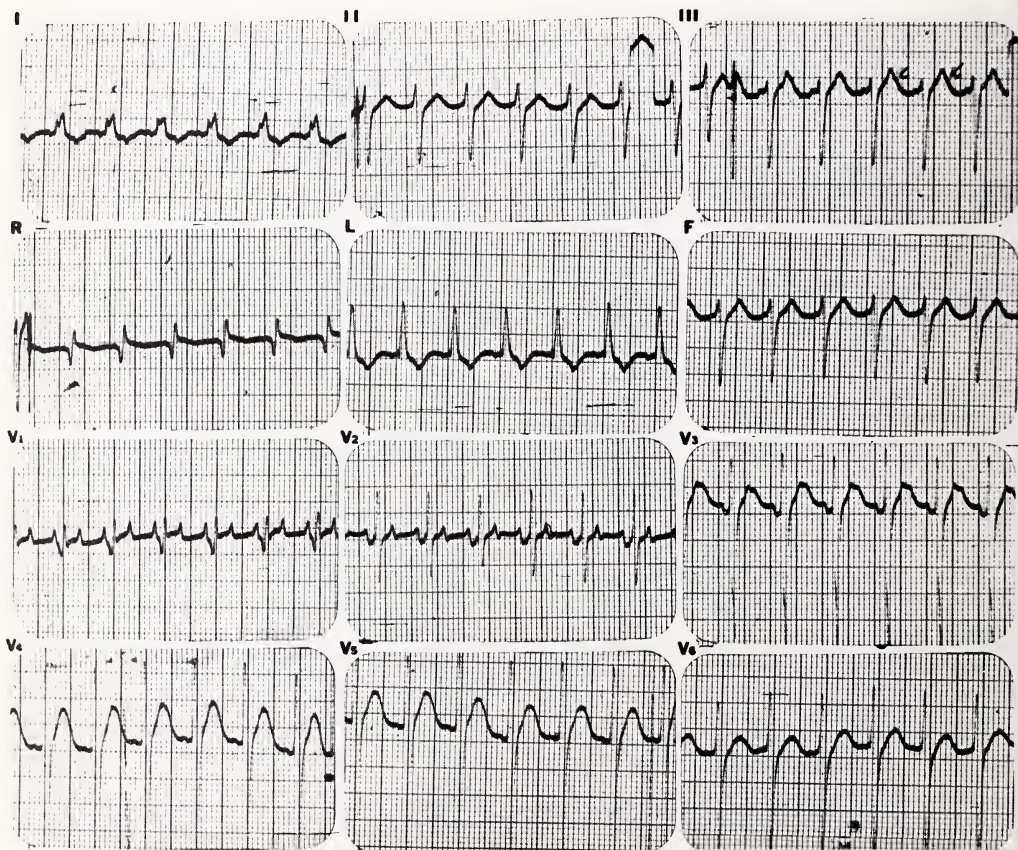


Figure 1

Figure one is a 12-lead ECG in an 84-year-old man obtained at the time of hospital admission with severe biventricular failure owing to long-standing coronary heart disease. There is an atrial tachycardia with 2:1 atrio-ventricular block; ectopic P-waves are best seen in right chest leads. In addition, there is a variety of contour alterations including abnormal septal forces, a superior axis and ST-T changes. Figure two is a continuous recording of a monitor lead obtained about one hour later. Strips A and C reveal

persistent atrial tachycardia with 2:1 atrio-ventricular block, while strip B shows superimposition of a paroxysmal ventricular tachycardia constituting a double ectopic

*Dr. Rothfeld is Director of the Heart Station and the Coronary Care Unit of Newark Beth Israel Medical Center, and Associate Professor of Medicine at New Jersey Medical School CMDNJ. He is a consultant to the editorial staffs of the *American Journal of Cardiology* and the *Journal of the American College of Chest Physicians*.



Figure 2

tachycardia. The clinical impression of digitalis toxicity was confirmed by immunoassay. Further laboratory studies disclosed pre-renal azotemia, moderate hypoxemia, dilutional hyponatremia and mild hypokalemia. Digitalis was withheld, and parenteral potassium and lidocaine were administered, but the patient died in heart failure several hours after admission.

DISCUSSION

Double tachycardias (DT) occur rarely and usually are due to digitalis toxicity¹. In 1960 Castellanos and his colleagues reviewed 35 previously reported cases and added 15 instances of DT that they collected between 1952 and 1958.² Nearly two-thirds of the combined series and coexisting atrial and ventricular tachycardia, and more than 75 percent were digitalis-induced. Most of the patients were elderly and had advanced coronary heart disease with refractory congestive failure. The prognosis was generally poor, because the majority died in heart failure despite termination of the DT by potassium and procainamide. These authors suggested that double tachycardias probably were underdiagnosed because of failure to identify the precise atrial activity. In questionable cases, esophageal or right atrial leads should be used because unrecognized DT may encourage further digitalization and inevitable death.

Wishner and his associates reported 11 cases of DT, all of which were coexisting atrial and junctional tachycardias.³ Most of the patients were old and in severe heart failure. All were digitalis-toxic, and 73 percent died. Interestingly, all

seven who continued to take digitalis died, while three of four patients in whom digitalis was withheld survived. These authors felt that prognosis was related primarily to recognition of DT as being due to digitalis toxicity rather than to the age of the patient, type of heart disease or laboratory abnormalities. The clinical characteristics and the prognostic features of this series differ from others probably because none of the patients had coexisting atrial and ventricular tachycardias.

SUMMARY

Double tachycardias represent the two characteristic effects of digitalis on the cardiac conduction system; acceleration of ectopic pacemakers and impairment of atrio-ventricular conduction. Although the prognosis is generally poor because of severe underlying myocardial dysfunction, prompt recognition of this uncommon mechanism is mandatory because some lives will be saved by withholding digitalis and administering potassium and procainamide-like agents.

REFERENCES

1. Rothfeld EL: Digitoxic arrhythmias. *J Med Soc NJ* 71:833-838, 1974.
2. Castellanos A, Azan L, Calvino JM: Simultaneous tachycardias. *Am Heart J* 59:358-373, 1960.
3. Wishner SH, Kastor JA, Yurchak PM: Double atrial and atrio-ventricular junctional tachycardia. *N Engl J Med* 287:552-553, 1972.

Duodenal Hematoma*

DONALD ROTHMAN, M.D., Red Bank

Every summer seemingly trivial trauma can lead to severe intraabdominal injury. A four-year-old boy was pushed into a bicycle handlebar and sustained a duodenal contusion. Persistent vomiting and complete gastric outlet obstruction

required surgery to release the compressive hematoma one week later. Alimentation within forty-eight hours was then normal.

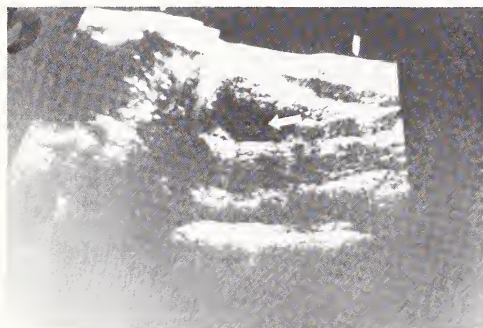


Figure 1—Ultrasound indicates elliptical mass (arrow) above great vessels.



Figure 2—Nearly complete duodenal obstruction (arrow) markedly delays gastric emptying. Barium remains in stomach overnight.



Figure 3—Surgical incision of the serosa releases the hematoma.

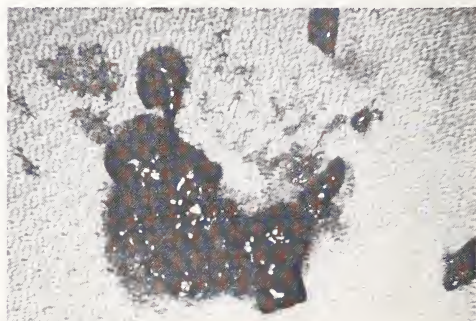


Figure 4—These clots were evacuated.

*From the Riverview Hospital, Red Bank, where Dr. Rothman is a member of the staff. He may be addressed at 565 Highway #35, Red Bank, N.J. 07701.

Pediculosis Upsurge

LEON G. SMITH, M.D., Newark*

Pediculosis upsurge, as predicted by the Center for Disease Control, has developed this fall (1980), not in the lower classes, or in people who are unclean, but in respectable, middle to upper-class people. There is an increase primarily in head lice and crab lice. Too often the diagnosis is overlooked in the upper economic people, and the itch is misinterpreted as dry skin, or as an allergic reaction. Once the diagnosis is suspected, a properly prepared microscopic specimen easily is done. If this is not available, a therapeutic trial of Kwell Lindane is recommended, with the properly stated safeguards in neonates and mucous membranes. Over-the-counter preparations containing chrysanthemum flower extract are almost as effective, under the trade names of A 200®, Pyrinate®, R.I.D.®, and XXX®. Repeat applications may be necessary to control the newly-hatched generation.

Since the lice are transmitted by direct contact and occasionally by clothes, schools should not be closed. Lice do not

jump or fly. They die in 48 hours, even in clothing and bedding, if they do not receive a blood meal. Fumigation is of no value. R & C spray can be used on environmental surfaces to kill lice and their nits, if the bed or clothing is needed immediately after contamination. Crab lice are more difficult to diagnose, as the lice often are imbedded under the curly pubic hairs. Sexual contact is the chief means of transfer of the crab lice. Occasionally, crab lice can be found on the eyelids, as well as elsewhere on the body.

Doctors in New Jersey can call the Infectious Disease Hotline—201-877-5482 (day), and 201-226-3359 (night and weekends) for more information.

*Dr. Smith is Director of Medicine and Chief of Infectious Diseases, Saint Michael's Medical Center, Newark, and Professor of Medicine and Professor of Public Health and Preventive Medicine, New Jersey Medical School, CMDNJ. He may be addressed at Saint Michael's, 268 High Street, Newark, NJ 07102.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physicians Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

This information is compiled by the Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Arnold and Marie Schwartz College of Pharmacy and Health Sciences, Long Island University.*

1. Do you have information concerning a new antianginal agent—nifedipine?

A new drug application for nifedipine (Procardia®), an antianginal drug by Pfizer, has been filed with FDA. Its chemical structure and mechanism of action are unlike presently available agents. The drug exerts a vasodilating effect on coronary and peripheral resistance blood vessels presumably by inhibiting cellular uptake of ionic calcium in vascular smooth muscles. In addition, it decreases cardiac workload and oxygen demand. Nifedipine acts rapidly after oral and sublingual administration and has been utilized to treat various types of angina, hypertension and acute left ventricular failure.^{1,2}

Goldberg *et al*³ utilized nifedipine in 12 patients with Prinzmetal's variant angina. Eleven of 12 patients had initial relief of symptoms and seven of the 11 had long-term relief. Withdrawal of the drug led to recurrence of angina in some patients. The authors concluded nifedipine may have a significant role in therapy of angina caused by coronary spasm.

Hernandez-Pieretti *et al*⁴ utilized nifedipine in 11 patients with anginal syndrome secondary to ischemic heart disease. Exercise electrocardiograms and workload performance were determined before and after administration of nifedipine. The authors found that there was significant reduction in number of anginal attacks and nitroglycerin tablets concomitantly consumed by patients during the drug period. There was also significant decrease in ST-segment depression and improvement in workload performance.

Guazzi *et al*⁵ treated 26 patients with severe primary hypertension with nifedipine. The investigators found the agent induced a prompt and large pressure reduction. Nifedipine administered sublingually to three patients with hypertensive encephalopathy and acute left ventricular failure resulted in significant reduction of systemic arterial and pulmonary arterial pressures.

Polese *et al*⁶ utilized nifedipine sublingually in 24 patients with acute pulmonary edema and favorable clinical and circulatory responses resulted. The drug apparently reduced preload and afterload and, possibly, improved myocardial contractility.

Ekelund and Oro⁷ conducted a double-blind study to evaluate antianginal efficacy of nifedipine alone and in combination with beta-blockers in 21 patients with stable angina pectoris. The authors found the combination resulted in increased exercise tolerances compared to nifedipine alone.

Side effects associated with nifedipine included flushing, dizziness, headaches and palpitations. It sometimes precipitated angina 30 minutes after a dose.^{1,2}

In conclusion, nifedipine has been used very successfully in various types of angina alone or in combination with nitroglycerin and/or beta-blockers. It also may be useful in treating patients with severe primary hypertension and acute pulmonary edema.

REFERENCES

1. Anon: *Facts and Comparisons*. St. Louis, MI Facts and Comparison, 1979, p 774.
2. Opie LH: Drugs and the heart: III. Calcium antagonists. *Lancet* 1:806-810, (April 12) 1980.
3. Goldberg S *et al*: Nifedipine in the treatment of Prinzmetal's (variant) angina. *Am J Cardiol* 44:804-810, (October 22) 1979.
4. Hernandez-Pieretti O *et al*: Antianginal effect of nifedipine in patients with ischemic heart disease. *Curr Ther Res* 18:39-42, (January) 1976.
5. Guazzi M *et al*: Nifedipine a new antihypertensive with rapid action. *Clin Pharmacol Ther* 2:528-532 (June 30) 1977.
6. Polese A *et al*: Clinical use of a calcium antagonistic agent (nifedipine) in acute pulmonary edema. *Am J Med* 66:825-830, (May) 1979.
7. Ekelund LG, Oro L: Antianginal efficiency of nifedipine with and without a beta-blocker studied with exercise test. A double-blind, randomized subacute study. *Clin Cardiol* 2:203-211, (June) 1979.

2. What is the significance of a drug interaction between ibuprofen and aspirin?

Several studies compared anti-inflammatory and analgesic properties of ibuprofen (sold as Motrin®) to aspirin, but little clinical data are available concerning their combined use. The ibuprofen package insert indicates, in animal studies, that aspirin given with non-steroidal anti-inflammatory agents yielded a net decrease in anti-inflammatory activity with lowered blood levels of the non-aspirin drug.¹ The insert

*The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm. D.; M.J. Berger, R.Ph., H. Boothe, B.S. Pharm.

also indicates that bioavailability studies in normal adults failed to show an effect of aspirin on ibuprofen blood levels.

Grennan *et al*² in a crossover, placebo-controlled study involving 30 patients compared effectiveness of combined ibuprofen-aspirin regimens to each agent administered singly. The combination of 2.4 gms/day of aspirin and 800 mg/day of ibuprofen provided no benefit over either agent administered alone. When a dose of 3.6 gms/day of aspirin was combined with 1600 mg/day of ibuprofen, a very weak additive effect was noted for control of pain, walking time and articular index. Salicylate levels essentially were unaffected by addition of ibuprofen, but there was significant reduction (56 to 59 percent) of ibuprofen serum levels when aspirin was added to the regimen.

Rubin *et al*³ showed a significant decrease in plasma fenopufen (sold as Nalfon®) levels, a drug chemically and pharmacologically related to ibuprofen, when given together with aspirin. This phenomena was observed whether fenopufen was administered orally or by intravenous injection.

In conclusion, studies in animals and humans indicated that a potential exists for a significant decrease in serum levels of non-steroidal anti-inflammatory agents, such as ibuprofen when administered concomitantly with aspirin. Combined use of these drugs with aspirin most likely should be avoided.

REFERENCES

1. Package Insert, Motrin® (Upjohn).
2. Grennan DM *et al*: Ibuprofen blood levels fall in combination with aspirin. *Br J Clin Pharmacol* 8:497 (Nov) 1979.
3. Rubin A *et al*: Interactions of aspirin with nonsteroidal antiinflammatory drugs in man. *Arthritis and Rheum* 16:635-645, (Sept-Oct) 1973.

3. Do you have information on dimethyl sulfoxide (DMSO) to treat arthritis?

For many years DMSO has been utilized as an industrial solvent and was found to possess a variety of pharmacological effects when applied topically.¹ Presently DMSO (sold as Rimso-50) is approved only for bladder instillation for symptomatic relief of interstitial cystitis, but its use in the

treatment of arthritis and muscle spasms has been proposed.^{2,3}

A multicenter, single-blind trial involving 274 patients with rheumatoid arthritis compared DMSO therapy to placebo.⁴ The drug or placebo was applied topically to involved joints twice daily for four weeks. Results indicated DMSO relieved joint pain and increased range of motion to a significantly greater extent than placebo. However, it didn't significantly decrease swelling and local heat.

Brown⁵ in a double-blind, controlled investigation that involved 75 subjects compared DMSO, placebo gel and standard therapy for the treatment of acute injuries and inflammation. Standard therapy varied and included corticosteroids, indomethacin (sold as Indocin®), phenylbutazone (sold as Butazolidin®), rest, diathermy and physical therapy. DMSO provided more rapid and significant relief of pain and tenderness than standard therapy or placebo gel. In DMSO-treated patients with acute strain, relief was for greater periods of time and there was significantly greater improvement in active and passive motion compared to other modalities. In the treatment of bursitis and tendinitis, results of standard treatment and DMSO were comparable.

Side effects reported to DMSO included skin irritation and a garlic-like odor attributable to a metabolite which is eliminated through the breath and skin.³

In conclusion, DMSO currently is approved for bladder irrigation in the treatment of interstitial cystitis but may have some value as a topical antiarthritic agent.

REFERENCES

1. Schultz HW: DMSO. *Pharm Index* 3:11-15, (Mar) 1976.
2. Anon: Agents used to treat urologic disorders, in *AMA Drug Evaluations* Chicago, 1980, pp 617-618.
3. Hussar DA: Important new drugs of the year. *Am Pharm* 19:249, (May) 1979.
4. Matsumoto J: Clinical trials of dimethyl sulfoxide in rheumatoid arthritis patients in Japan. *Ann NY Acad Sci* 560-568, (Apr-Oct) 1965.
5. Brown JH: A double-blind clinical study—DMSO for acute injuries and inflammations compared to accepted standard therapy. *Curr Ther Res* 13:536-540, (Aug) 1971.

The DMSO Controversy — A Congressional Perspective

THE HONORABLE ROBERT A. ROE, Washington, D.C.*

There are an estimated 31 million Americans suffering from the chronic pain of arthritis. To date, there have been no major medical breakthroughs in finding a cure for this crippling disease. Many of those afflicted with arthritis, who see no hope for an end to their suffering, turn to charlatans who peddle worthless and ineffective cures. Millions of others take pain pills on a daily basis to reduce ever-present aches associated with bursitis, rheumatism and other disorders of the muscular-skeletal system.

For the first time, there is hope on the horizon for the sufferer of arthritis as well as a plethora of other painful conditions. A simple and inexpensive compound, known as DMSO (Dimethyl sulfoxide), is available and appears to provide quick and simple pain relief.

Unfortunately, a roadblock has been set up that is preventing DMSO from being made available to the American public on a large-scale basis. That hindrance is coming from none other than the Federal Food and Drug Administration (FDA). Despite strong evidence that DMSO is a potent arthritis pain reliever, the FDA has authorized very few tests to determine its effects on humans and has not begun any studies of its long-term potential for treating arthritic diseases.

To correct that situation, I have sponsored legislation in the House of Representatives mandating clinical studies by the National Institute for Arthritis, Metabolism and Digestive Diseases to determine the safety and effectiveness of DMSO for use by patients with arthritis and other highly painful diseases.

DMSO, which was discovered in 1866 by a Russian scientist, is derived from lignin, a sticky substance that binds woody cells in trees. It attracted little attention until the 1950's when industrial uses were found for it. British scientists were startled to find that when DMSO was combined with water, it reduced the formation of ice crystals at low temperatures. They found DMSO to be very helpful in preserving frozen red-blood cells.

The leader in determining DMSO'S medical uses has been Dr. Stanley Jacob, a surgeon with the University of Oregon Health Services Center. In experiments with rat burns, Dr. Jacob found that DMSO was a painkiller. It reportedly creates a reversible electro-chemical around nerve endings that would otherwise send pain signals to the brain.

Dr. Jacob has identified four major uses of DMSO: arthritis, the treatment of such injuries as strains and sprains, severe head injuries, and certain skin infections.

By 1965 it was estimated that more than 100,000 persons

were utilizing DMSO to treat the conditions outlined by Dr. Jacob. That year, the FDA, with the thalidomide birth defect scandal still on its mind, learned from animal studies that DMSO might cause eye damage. As a result, all testing on DMSO was halted.

As a consequence of that action, DMSO developed into a "hot item" on the medical black market. DMSO officially was limited to veterinary use, but for more than ten years, doctors prescribed the medication to their patients "under the table." More alarming were the fraudulent Mexican clinics that sprang up charging exorbitant rates to Americans seeking relief from pain.

Finally in 1978, the FDA approved the first human use of DMSO, but only in low concentrations for interstitial cystitis. The Research Industries Corp., a small Utah firm, received the FDA approval to use DMSO for interstitial cystitis based on human studies done by Dr. Bruce Stewart of the Cleveland Clinic and Dr. Sheridan Shirley of the University of Alabama.

Last year, the hope for DMSO's emergence on the medical scene received another setback, when the FDA refused to approve its use for scleroderma. The reason given by the FDA was that DMSO did not meet its efficacy standards in a controlled laboratory experiment.

The efficaciousness of the drug has been difficult to prove in the laboratory because it cannot meet the standards of the "double-blind" test due to the garlic or oyster-like taste that occurs when the drug is applied topically. Also, DMSO has a systemic effect in that it enters the bloodstream upon application and, as a result, it will not only treat the area to which it was applied, but other areas of the body as well.

There no longer seems to be any question, even on the part of the FDA, that DMSO is not a dangerous drug.

Dr. Arthur L. Scherbel of the Cleveland Clinic, who has done much of the scleroderma-DMSO work, said that a double-blind study would be impossible. He added that DMSO relieves the pain that many scleroderma patients suffer and should be put into widespread use.

The FDA does not buy that argument. While the federal agency debates what to do next, many scleroderma patients may have to have their fingers and toes amputated and thousands of arthritic patients will suffer needlessly because DMSO has not been proved effective in FDA laboratory tests.

*United States Congressman for the 8th District. He is chairman of the House Economic Development Subcommittee of the Public Works Committee and ranking member of the House Science and Technology Committee. He may be addressed at 2243 Rayburn Bldg.

Another roadblock to more expanded use of DMSO has come from the pharmaceutical industry itself. DMSO is a relatively cheap substance, costing not more than \$4 a quart to produce. Add that to the fact that DMSO is a common chemical solvent on which no drug company can get an exclusive patent and you have eliminated the major financial incentives.

Last March, the nation's top-rated television show "60 Minutes" devoted a segment to the DMSO issue which provoked the largest outpouring of viewer response in the program's 12-year history. The program asked why a relatively easy-to-produce substance, that has proved itself in many instances as a pain reliever, is not being made available to the general public. The show concluded that despite the fact that millions of people are clamoring for the drug, the FDA stalemate over its use can be resolved only through Congressional action.

Steps quickly are being made in that direction. My close friend, Representative Claude Pepper, chairman of the House Select Committee on Aging, recently conducted hearings on DMSO. The following are the conclusions drawn by the committee as a result of evidence given to it by some of the top medical experts in the nation:

—There is little doubt that DMSO is effective in reducing pain caused by arthritis, that it is effective in helping to reduce swelling and promote healing in soft tissue injuries. It may have value in healing skin ulcers such as those produced by the disease scleroderma. It may help to promote healing in first and second-degree burns, in limiting damage of spinal cord injuries and in relieving intracranial pressure caused by head injuries. It is an open question as to whether it helps arthritis. It does relieve pain but no one knows whether it reduces the inflammation, which is the underlying cause of the pain. In addition to its other properties, DMSO heightens the effect of other drugs and may be useful as a carrier of other substances by its absorption qualities through the skin.

—The absence of scientific tests acceptable to the FDA and lack of interest by major drug firms have been the primary reasons why DMSO has not been made available to the general public. The problem is that the FDA does not initiate tests. The FDA must wait for major drug companies to come forward and ask to test a product for certain uses. Since DMSO is an agent commonly found in nature, and produced

easily and inexpensively, it is not thought to be patentable. Drug companies ask why they should spend millions to get FDA approval when there is no assurance they will have exclusive right to market the drug if that is approved. Because of its status, DMSO has been included in a category of so-called orphan drugs.

—DMSO has been approved for use in about a dozen nations, including the Soviet Union, West Germany, Switzerland and several South American nations. Two states, Oregon and Florida, have passed their own laws legalizing the use of DMSO by physicians. Doctors cannot lose their licenses for prescribing DMSO in those states. The committee also discovered there was widespread bootleg use of DMSO in professional sports.

In my position as ranking member of the House Science and Technology Committee, I strongly have pushed for extensive testing to determine the true facts as to how DMSO can be helpful to the millions of Americans suffering from chronic pain. I am confident the medical establishment supports me in those efforts.

The legislation I have sponsored calling on the National Institutes of Health to conduct investigation of the safety and efficacy of DMSO within a year has been included as an amendment to the Health Research Act of 1980. Other legislative actions related to DMSO include a recently introduced bill calling for the establishment of a National Center on Clinical Pharmacology. It would be the center's responsibility to watch for and test so-called orphan drugs and alert the FDA to drugs, whether produced in this country or abroad, which may have therapeutic value. No dollar amounts are included in the bill.

Another proposal, which is being drafted, would provide drug companies with incentives to seek FDA approval of drugs which are not thought to be patentable. It would give a drug company the exclusive rights to market a product in interstate commerce for three years after it won FDA approval.

Other members of Congress with whom I have discussed the DMSO issue indicated they also have received hundreds of letters and phone calls urging quick action on the drug matter.

Because of that public outpouring of concern it appears that definite decisions on the future of DMSO will be made by the new 97th Congress.

215th Annual Meeting Medical Society of New Jersey May 15-19, 1981

Housing Application The Meadowlands Hilton

Please Reserve: _____ Single _____ Double _____ Twin _____ Suite

Arrival: (date) _____ at (time) _____

Departure: (date) _____ at (time) _____

Name _____

Address _____

City _____ State _____ Zip Code _____

If double or twin name of person joining _____

Single: \$56

Twin: \$67

Double: \$67

Suite: \$150 and up

If range of rates is offered and rate requested is not available, the next available rate will be assigned. Reservations must be received no later than two (2) weeks prior to the opening date of your meeting and will be held until 6 p.m. on day of arrival unless otherwise specified.

(New Jersey Sales Tax - 5%)

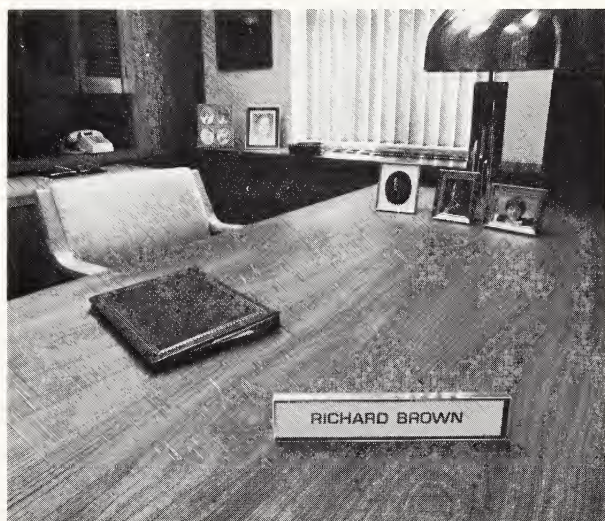
Complete and mail this application to: Front Office Manager
The Meadowlands Hilton
Two Harmon Plaza
Secaucus, New Jersey 07094

Richard Brown thought he was too young to have a heart attack. He wasn't.

Because having a family, a good job and a bright future doesn't protect anyone from heart attack. In fact, nearly one million Americans — many with those assets — die of heart disease and stroke each year. And 200,000 of them die "too young."

The American Heart Association is fighting to reduce early death and disability from heart disease and stroke with research, professional and public education, and community service programs.

But more needs to be done.



You can help us support research and education by sending your dollars today to your local Heart Association, listed in your telephone directory.

**Put your money where
your Heart is.**



**American
Heart
Association**

WE'RE FIGHTING FOR YOUR LIFE

DOCTORS' NOTEBOOK

Trustees' Minutes November 16, 1980

A regular meeting of the Board of Trustees was held on Sunday, November 16, 1980, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

National Policy Advisory Council . . . Noted that President-Elect Reagan has named an 18-member National Policy Advisory Council to review health care issues.

Legal Services Plan . . . Noted that 3,413 members of MSNJ are enrolled in the Legal Services Plan. Statistical data on the first six months of operation will be reported to the Board of Trustees.

Membership . . . Noted that (1) AMA membership from New Jersey totals 5,301 (6,247 according to AMA records, which include physicians who pay directly to the AMA and additional exempt members); (2) paid membership in MSNJ is 7,656 as of October 31—there are 908 exempt and 621 emeritus members.

State Board of Medical Examiners vs. Driggs . . . Noted that the State Board of Medical Examiners has presented a motion for a remand of the case out of the Appellate Division back to the State Board so that a rehearing may be held to review newly discovered evidence.

IRS Determination on Subordinated Loan Payments . . . Noted that MSNJ has retained outside tax counsel to represent its members via a class action contesting the IRS position in denying the business expense deductibility of subordinated loan payments made to the Medical Inter-Insurance Exchange of New Jersey. Physicians are asked to have their accountants or tax advisors contact T.K. Heaney & Associates in King of Prussia, PA.

Radiological Regulations . . . Noted that the State Board of Medical Examiners' ruling on the provision of mandatory radiological services to chiropractors is being opposed in joint litigation by MSNJ and other interested parties. Oral arguments have been held.

MSNJ Charter Change . . . Senate Bill 1390 which would amend and revise the statutory charter of MSNJ has been reported out of the Senate Committee on Labor, Industry and Professions with an amendment which deletes the Society's right to grant the M.D. degree.

Loan Agreement . . . Noted that in accordance with authorization of the Board on October 19, a loan agreement has been made with Princeton Bank and Trust to finance the unanticipated expenditure for the roof replacement and accelerated construction costs for office space for the New Jersey State Medical Underwriters.

Controlled Dangerous Substances Prescriptions . . . Noted that a State Board of Medical Examiners' proposed change requires that "each prescription for a controlled dangerous substance shall be written on a separate prescription blank." No official comment will be made on the proposal since it already is standard practice by physicians.

Senate Bill 1578 . . . Voted to support the position of the New Jersey Hospital Association on Senate Bill 1578 which would prevent the Commissioner of Health from including any new hospitals in the DRG system until after September 15, 1981. The Hospital Association supports the bill with an amendment allowing a hospital to participate voluntarily.

Rubella Screening of All Health Care Employees . . . Noted that a request from the New Jersey Hospital Association for the Society's position concerning NJAC 8:31-26.3—rubella screening of all health care facilities' employees—is being reviewed by the Committee on

Maternal and Child Care and a report will be presented to the Board.

MSNJ Student Association . . . Referred a communication from the MSNJ Student Association, urging New Jersey's AMA Delegation to reject specific revisions in the Liaison Committee on Graduate Medical Education's requirements for approval of residency programs and to support the Equal Rights Amendment, to members of the New Jersey AMA Delegation for its consideration.

HSA Observation Organizations . . . Referred the following recommendation from the Council on Medical Services to the New Jersey Foundation for Health Care Evaluation for study and comment:

That the Board of Trustees explore the use of the New Jersey Foundation for Health Care Evaluation as an avenue for cooperation and financial support in relation to physician participation in the HSAs.

Committee on Annual Meeting . . . Approved the following recommendations from the Committee on Annual Meeting:

1. That MSNJ accept for its annual meetings the 1982 and 1983 dates offered by Resorts International Hotel and that at the end of the 1983 annual meeting bids from other Atlantic City hotels be sought in an effort to obtain the best facilities available.

2. That informational exhibits be eliminated and that scientific exhibits be limited to New Jersey exhibitors only.

3. That table space be made available at the annual meeting for the Academy of Medicine, the Drug and Alcohol Abuse Committee, JEMPAC, the New Jersey Foundation for Health Care Evaluation, MSNJ's Student Association, and the Society for the Relief of Widows and Orphans.

4. That the Motion Picture Theatre not be scheduled for 1981.

5. A motion to return the Golden Merit Award Ceremony and Reception to the Society's headquarters in Law-

renceville because of space limitations at the Meadowlands Hilton was defeated.

6. That there be a charge of \$5 per person for food at the Inaugural Reception.

7. That requests for additional programs (malpractice insurance, DRG workshop, and others) be denied on the basis that the schedule already is overcrowded.

8. That a proposed program on impaired physicians be referred to the Section on Psychiatry for possible inclusion in its scientific session.

Newborn Record Log Book . . . Approved the following recommendation from the Committee on Maternal and Child Care:

That the Newborn Record Log Book, as presented by the Subcommittee on Neonatal Record Keeping, be made available to all New Jersey hospitals with a maternity department. In order to enhance the cooperation of the institutions involved, the first edition will be issued free of charge.

Sex Education in the Schools . . . Noted that in response to a directive from the 1980 House of Delegates and the Board's request for an explanatory report from the Committee on Maternal and Child Care regarding its communication to the State Board of Education concerning mandated family life education, the Committee relied upon previous action of the House of Delegates which was to support sex education in the schools.

Retirement Plan for Physicians . . . Defeated a recommendation from the Committee on Retirement Plan for Physicians that the Medical Society of New Jersey offer its members the personal financial review proposed by PRO Services.

Committee on Publication . . . Approved a recommendation that the Medical Society of New Jersey contract for the 1981 production of *The Journal*, MSNJ, with Hughes Corporation and Trentyp, Inc.

Committee on Medicine and Religion . . . Approved a recommendation from the Committee on Medicine and Religion that the Board of Trustees approve a 90-minute panel program for presentation at the 1981 Annual Meeting entitled "Ethics—Law—Medicine: The Impact of Ethical Values on Clinical Decision Making." The panelists will include a theologian, a lawyer and a physician.

Perinatal Designations . . . Noted that it

was the unanimous decision of the members attending the September 24 meeting of the New Jersey Association of Medical Specialty Societies to support the position of the American Academy of Pediatrics, New Jersey Chapter, which favors the concept of regionalization but opposes the plan for perinatal designations presented by the Commissioner of Health.

Reinstatement Policy for Dues-Delinquent Members . . . Noted that Essex County Medical Society objects strongly to the proposed reinstatement policy for dues-delinquent members and deferred further consideration of the matter until after the House of Delegates' meetings at the 1981 Annual Meeting.

Physicians' Assistant Bill—A-1753 . . . Noted that the Physicians' Assistant Bill (A-1753) which MSNJ is actively opposing is out of committee.

Widows and Orphans Society . . . Approved a request from the President of the Society for the Relief of Widows and Orphans to designate April as "Widows and Orphans Month."

January/February Meetings of the Board of Trustees . . . Agreed to meet on February 1 in view of a conflict of the customary date with the AMA Leadership Conference in Chicago, February 12 to 15. There will be no meeting in January.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

Interest has been expressed in the possible long-term effects of the DRG program and the prospective payment system enacted under S-446. Given the myriad uncertainties over validity, accuracy, and effectiveness, this is a difficult task. Indeed, short-term results are unclear at this point. Assuming, however, that there is some usefulness, or the *appearance* of effectiveness in the method, some of the following may occur:

1. Substitution of DRG for all utilization programs, including PSRO.
2. Adoption of prospective rate-setting methods for all Medicare patients in the nation.
3. Extension of payment by diagnosis to physicians and other providers.
4. Linkage of reimbursement to planning:

- (a) Regionalization of primary, secondary, and tertiary care facilities.
- (b) Change in training programs toward more primary care and less specialty care.
- (c) Use of certificate-of-need process to promote "cost-effective" facilities and services.
5. Publication of lists of hospitals, including comparison of costs of services.
6. Trend toward "public utility" methods of regulating and reimbursing medical care.
7. Closure of "inefficient" hospitals; conversion of unused acute-care beds to other types of care, such as long-term.
8. Increase in the use of ambulatory services, particularly for diagnostic purposes.
9. More uniformity in utilization of hospitals when all are subject to the same rules.
10. More pressure for increasing long-term care services and facilities.

The above list, not complete, assumes that DRG will succeed, which is far from certain. The *appearance* of effectiveness was mentioned previously. In this cost-reducing atmosphere, the symbols and slogans of promise take on aspects of reality to those in search of solutions. Some of this already is apparent: the Comptroller General, in a report to Congress (September, 1980),¹ urges HCFA to move forward with prospective rates for all Medicare cases and not to wait the evaluation to be delivered in 1982. Prospective rates for dialysis patients are being pushed by HCFA.

Changes in national and state administrations probably will result in the discontinuance of some regulatory programs, but the pressures for cost containment will remain. The DRGs may survive in another form. Over time, some of the DRG groups will be found useful, many will not. Redefinition of the more heterogeneous groups will go on, but many will remain useless for data processing and reimbursement. Some other proposed process probably will emerge with another name or slogan. The search for a workable system for identifying and controlling health care processes will go on.

Not all of the possible long-term results are without merit. Reduction in unnecessary use of hospital beds; better provision of appropriate coverage for ambulatory and long-term care can make for greater efficiency. Awareness of physicians of the cost implications of the orders which they write should be beneficial. If DRG and S-446 turn out to be less effective than anticipated, you

¹ Report by the Comptroller General of the United States: Rising hospital costs can be restrained by regulating payments and improving management. Washington, DC, Superintendent of Documents, US Printing Office, September 19, 1980.

can expect much of the blame to be aimed at the medical community. Physicians need to be kept abreast of the system and its implications and imperfections. We should offer our advice on appropriate groupings and terminology. We also should make it clear that we are not responsible for all of the inflation in medical and hospital costs. Professor Eli Ginzberg, himself a distinguished economist, says that economists: "don't understand how medicine operates, because they're basically anti-physician," and: "most of what economists say is 100 percent mishmash, whether they're talking about the planning model or market model."² This does not mean that economists are all wrong, or that physicians are always right. We are in the age of economic analysis of what doctors do and how much it costs. Like it or not, we at least should be prepared to point out the errors in their statistics, and the meaning behind their groups of numbers. Instead of wondering about long-term results of their efforts, we may be able to influence those results for the benefit of our patients.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

New and enhanced health care services and health education opportunities are in store for South Jersey with the recent opening in Camden of the first Area Health Education Center (AHEC) program in the State. The AHEC program, a \$48-million federal and state investment, is administered by CMDNJ and consists of a consortium of health care and educational institutions in South Jersey. With \$5 million in federal funds and \$3 million in state funds, the program has been in planning and developmental stages for the past two years.

The Camden AHEC program represents a challenge to all involved, because it is only the third of four such urban-based programs designated by the federal government since the AHEC legislation became law more than a decade ago. That law is designed to increase health care services in areas specified as underserved, and by any yardstick

Camden meets that criterion. Nationwide, there are 21 AHECs, primarily in rural areas.

The broad AHEC concept was advanced, according to the law, "for the purpose of improving the distribution, supply, quality, utilization, and efficiency of health personnel in the health services delivery system and for the purpose of encouraging the regionalization of educational responsibilities of health professions' schools."

The federal government's eight-year contract with CMDNJ and the state calls for the development of two distinct AHEC regional centers, with the possibility of a third. The first, called the Greater Camden AHEC, opened in November, with the Camden County Health Department responsible for this inner city AHEC's clinic facilities. The second, called the Central Camden AHEC, now is being planned at three area hospitals—Cooper Medical Center, Our Lady of Lourdes and West Jersey Hospitals. It is due to open in October, 1981.

A three-phased plan for the opening of the Greater Camden AHEC was initiated in November. Its health care services component calls for providing comprehensive, family-centered ambulatory care to a population that is expected to reach 6,000 by 1982. First base of services to open its doors was the East Camden Family Practice Center, an existing facility which previously provided mostly screening and preventive services to the community. This facility is being expanded to enhance the new services.

The second clinic center, the Bergen Lanning Family Practice Center, is under construction and due to open next month (February). The third clinical center is scheduled to open in an as yet undecided location after July, 1982.

CMDNJ is hopeful that the AHEC program will create a mushrooming effect that will take an underserved area and turn the picture completely around. The full scope of the program is one of long-term, constantly expanding gains that will continue to self-perpetuate. The years of planning, as well as the financial investments and the professional resources and expertise involved, all are aimed at bringing the citizens of this area the same opportunities for gaining comprehensive, continuous preventive care now enjoyed in other areas of the state.

The first step toward that goal will come from the first two family practice centers. All families being registered at

the East Camden site will receive continuous "family centered" care from a team of professionals that will remain consistent for every patient.

The medical education component for the Greater Camden AHEC is being provided by the Camden-based CMDNJ-New Jersey School of Osteopathic Medicine, whose third and fourth-year students will both train and provide support services at the clinics under physicians' supervision. These students are based at John F. Kennedy Memorial Hospital, Stratford, which is the school's core teaching hospital.

When the Central Camden AHEC opens, the medical education component will be served by faculty and students of CMDNJ-Rutgers Medical School at Camden. Students of this school receive their clinical education at Cooper Medical Center.

In addition to the medical students, others to be involved in the AHEC program will include students from CMDNJ's Newark-based schools of dentistry and allied health professions; students in Rutgers University's social work department in Camden; students in the nutrition program at Camden County College, and health education students from Glassboro State College. All educational components are geared to training students to work in the urban environment, where they will be encouraged ultimately to establish their careers.

Health care delivery teams at the center will be led by a family physician from the faculty of the osteopathic medical school, assisted by nurses and nurses' aides of the Camden County Health Department. Also working at the clinics will be postgraduate physicians who have undertaken the family practice specialty.

The East Camden center is initially composed of four modernized examination rooms, a supporting laboratory facility, conference rooms and a redesigned, renovated reception area. This will be expanded by a 1,700-square-foot modular building, with clinical facilities, in the next few months.

Services at the family practice centers will stress ambulatory primary care with emphasis on prevention and early treatment. In addition to screening for lead poisoning, hypertension, venereal diseases and tuberculosis, patients will be provided with regular physical examinations and counseling on health and nutrition. Specialty care will be available at set times by CMDNJ experts in pediatrics, obstetrics and gynecology, in-

²Ginzberg Eli: cited in *AMA News*, November 14, 1980.

ternal medicine and psychiatry.

In emergency cases, where a patient's condition requires a referral to a specialist, those services will be coordinated by the attending family physicians, who will accompany the patient during visits to other facilities when indicated. Area hospitals are serving as supporting facilities in the AHEC program. All fees for services are on a sliding scale basis, with third party insurers such as Medicaid or Medicare used when appropriate.

Federal support for an AHEC program in Camden County grew out of a

desperate need for health services graphically underscored by studies that revealed the deficiencies in the area's health care situation. CMDNJ's role in South Jersey began as early as 1971, when a feasibility study was undertaken to bring a medical education program to the area. In 1975, Governor Brendan Byrne signed legislation directing the College to develop both osteopathic and allopathic programs there.

In September, 1977, the CMDNJ-New Jersey School of Osteopathic Medicine opened its doors to its inaugural

class, now in clinical training in South Jersey. The allopathic program, which is a function of the Piscataway-based CMDNJ-Rutgers Medical School, is also in operation at Cooper Medical Center.

This sharing of expertise of both medical programs in the establishment and operation of the AHECs further will cement the unified spirit at CMDNJ, which already has become our greatest strength through the sharing by the two schools of basic science faculty and facilities in Piscataway.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Eric J. Schenkel, M.D., Park Drive Manor, Apt. A-1212, Philadelphia, PA 19144. Einstein 1976. Also, general internal medicine. Board certified (IM). Group, partnership, academic. Available August 1981.

ANESTHESIOLOGY—Ramesh M. Nayak, M.D., 800 Sawyer Hall, 2910 Scioto Street, Cincinnati, OH 45219. Seth G.S. Medical (India) 1971. Board eligible. Solo, small group. Available.

CARDIOLOGY—Sheldon Eisenberg, M.D., 300 Community Drive, Manhasset, NY 11030. Cornell 1976. Also general internal medicine. Board certified (IM). Non-invasive techniques, hospital based, or single or multi-specialty group. Available July 1981.

Richard J. Butcher, M.D., Geisinger Medical Center, Danville, PA 17822. University of Pennsylvania 1973. Board certified (IM). Group or partnership. Available July 1981.

FAMILY PRACTICE—C. Chin, M.D., 1016 Washington Garden Apts., Washington, NJ 07882. SUNY-Stonybrook 1979. Board certified. Part-time clinic, ER or housestaff duty. Available.

Mark Scheier, M.D., 24 Paerdegat Third Street, Brooklyn, NY 11236. Guadalajara (Mexico) 1977. Board eligible. Group, partnership, multi-specialty group. Available July 1981.

Winthrop C. Dillaway, III, M.D., 322 W. 57th Street, Apt. 45-L, New York, NY 10019. Guadalajara (Mexico) 1975. Board

certified. Solo (home office). Available.

Stephen Kay, M.D., 22745 Kelly, East Detroit, MI 48021. Innsbruck (Austria) 1949. Board eligible. Solo. January 1981.

GASTROENTEROLOGY—Jacques M. Schmid, M.D., 225-F Edgemoor Road, Bridgeport, CT 06606. Einstein 1976. Also general internal medicine. Board certified (IM). Any type practice. Available July 1981.

GENERAL PRACTICE—Kirit D. Trivedi, M.D., 546 West Ridgeway Street, Warrenton, NC 27589. Baroda (India) 1967. Board certified. Partnership or group. Available June 1981.

Martin L. Schlein, M.D., 106 Merrifield Court, Greenville, SC 29615. Tel Aviv (Israel) 1973. Group, partnership, solo. Available.

Carlos A. Viola, M.D., Avenida Cordoba 77 Oeste, San Juan 5400, Argentina, South America National University, Buenos Aires 1950. Also, general surgery. Institutional, group, or partnership. Available.

INFECTIOUS DISEASES—David Brooks, M.D., P.O. Box 33172, San Diego, CA 92103. Dublin (Ireland) 1962. Also general internal medicine. Available.

INTERNAL MEDICINE—Brijinder Singh Kochhar, M.D., 8501 Fort Hamilton Parkway, Apt. 2-A, Brooklyn, NY 11209. Patiala (India) 1970. Also, pulmonary medicine. Board certified. Any type practice. Available July 1981.

John R. Kalloz, M.D., 109 Green Street, Danville, PA 17821. Pennsylvania State 1978. Board eligible. Single or multi-specialty group. Available July 1981.

Ramulu Eligeti, M.D., Deborah Heart & Lung Center, Browns Mills, NJ 08015. Osmania (India) 1972. Subspecialty, cardiology. Solo or partnership. Available July 1981.

Ben Praport, M.D., 14 Country Club Lane, Elizabeth, NJ 07208. Israel 1975. Subspecialty, gastroenterology. Board eligible.

Any type practice. Available July 1981.

Mohammad Razav Rahman, M.D., 309 Birchwood Court, North Brunswick, NJ 08902. Dow (Pakistan) 1974. Board eligible. Group, solo, institutional. Available.

M. S. Chakrabarty, M.D., 155 East Godfrey Avenue, Ashbourne Manor, E-506, Philadelphia, PA 19120. Grant Medical (India) 1972. Subspecialty, gastroenterology. Board certified. Solo, partnership, group. Available July 1981.

David J. Stone, M.D., 105 Stewart Circle, Charlottesville, VA 22903. NYU 1974. Board eligible. Group. Available July 1981.

Howard Allen Sackel, M.D., 39 Cottonwood Drive, Stoughton, MA 02072. SUNY-Upstate 1976. Subspecialty, nephrology. Board certified. Group or partnership. Available July 1981.

Sharon D. Warner, M.D., 115 Old Short Hills Road, Apt. 274, West Orange, NJ 07052. SUNY-Downstate 1978. Board eligible. Partnership, single or multi-specialty group. Available July 1981.

Martin Lerman, M.D., 3258 Lauriston Place, Fairfax, Virginia 22030. Georgetown 1973. Board certified. Any type practice. Available.

Fayez A. Roumani, M.D., P.O. 522, Bradford, PA 16701. Damascus (Syria) 1973. Subspecialty, nephrology. Board eligible. Group or hospital-based. Available.

Steven Rosner, M.D., 150 Colton St., Apt. 3-D, Staten Island, NY 10305. New York Medical College 1976. Subspecialty, rheumatology. Board certified. Group, partnership. Available July 1981.

Robert J. Moran, M.D., 801 East 10th Street, Brooklyn, NY 11230. SUNY-Downstate 1977. Board eligible. Group, partnership, or hospital-based. Available July 1981.

NEPHROLOGY—Krishnababu Chunduri, M.D., 2121 Shore Parkway, Apt. 2-F, Brooklyn, NY 11214. Guntur (India) 1973. Board eligible. Solo or group. Available January 1981.

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREbro-NICIN® capsule
contains:

Pentylenetetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Vijay K. Nellore, M.D., 33-A West 23rd Street, Bayonne, NJ 07002. Osmania (India) 1973. Solo, group, or institutional. Available July 1981.

NEUROLOGY—Alan J. Friedman, M.D., 114 Adena Road, West Newton, MA 02165. Cornell 1974. Board certified (IM). Board eligible. Group or partnership. Available July 1981.

OBSTETRICS/GYNECOLOGY—Gary S. Rosenberg, M.D., 245-20 Grand Central Parkway, Bellerose, NY 11426. SUNY-Downstate 1977. Solo, group, partnership. Available July 1981.

Shreedhar P. Abhyankar, M.D., 15-J Sycamore Drive, Norwalk, OH 44857. B.J. Medical (India) 1971. Board eligible. Solo, partnership, group, (small or medium-sized town). Available.

ONCOLOGY—D. S. Prajapati, M.D., 88 Slate Creek Drive, #5, Cheektowaga (Buffalo) NY 14227. Baroda (India) 1972. Board certified. Group, partnership, solo. Available July 1981.

Steven E. Zimmerman, M.D., 7562 Westlake Terrace, Bethesda, MD 20034. Cornell 1976. Also, general internal medicine. Board certified (IM). Group or partnership preferred, also solo. Available July 1981.

OTOLARYNGOLOGY—Howard Taylor, M.D., 8201 Henry Avenue, Apt. P-3, Philadelphia, PA 19128. Columbia 1972. Board eligible. Partnership, group. Available July 1981.

PATHOLOGY—Kaushik J. Pandya, M.D., 30-49 70th Street, Jackson Heights, NY 11370. Baroda (India) 1974. Any type practice. Available July 1981.

Maneala V. Betkerur, M.D., 10015 S. Hill Terrace 28/202, Palos Hill, IL 60465. Karnatak (India) 1974. Subspecialty, neonatology. Board certified. Group, institutional. Available July 1981.

Aiylam P. Sivaramakrishnan, M.D., 3520 Keystone Avenue, #3, Los Angeles, CA 90034. Seth G. S. Medical (India) 1971. Subspecialty, pediatric cardiology. Board certified. Group, institutional, hospital-based, HMO. Available.

Sitamahalakshmi Nutakki, M.D., 22 Metropolitan Oval, #5G, Bronx, NY 10462. Guntur (India) 1970. Board eligible. Group or partnership. Available January 1981.

PEDIATRICS—Anil G. Pradhan, M.D., 118 Grove Park, Fort Dix, NJ 08640. Bombay (India) 1972. Board certified. Solo, partnership, associate, group. Available March 1981.

RADIOLOGY—U. Chaibongsai, M.D., 992 Woodmere Drive, Westfield, NJ 07090. Siriraj (Thailand) 1968. Board certified. Part-time, group, partnership. Available. Indu M. Solanki, M.D., 266 Beaufort Avenue, Livingston, NJ 07039. B.J. Medical (India) 1967. Board certified. Solo, group, or partnership. Available.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available July 1981.

Thomas A. Giangrasso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available July 1981.

SURGERY, GENERAL—Zahur U. Azhar, M.D., 1684 Central Avenue, Bridgeport, CT 06610. Nishtar (Pakistan) 1963. Board eligible. Solo. Available July 1981.

Dariusz Vaziri, M.D., 7510 Brompton Court, Apt. 587, Houston, TX. Tehran (Iran) 1974. Also, vascular surgery. Board eligible. Group, partnership. Available August 1981.

Carlos A. Viola, M.D., Avenida Cordoba 77 Oeste, San Juan 5400, Argentina, South America. National University, Buenos Aires 1950. Also, general medicine. Institutional, group, or partnership. Available.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available July 1981.

Inder J. Singh, M.D., WCMC #1-C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available July 1981.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available July 1981.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available June 1981.

UROLOGY—Elliott Lieberman, M.D., 16-66 Bell Boulevard, Apt. 730, Bayside, NY 11360. SUNY-Downstate 1976. Group or partnership. Available July 1981.

William Kohlberg, M.D., 3450-17A Wayne Avenue, Bronx, NY 10467. Pittsburgh 1975. Board eligible. Group or partnership. Available July 1981.

Paul A. Church, M.D., 435 East 70th Street, Apt. 27-C, New York, NY 10021. Cornell 1975. Board eligible. Solo, partnership, group. Available June 1981.

Vasant Betkerur, M.D., 10015 South Hill Terrace, 28/202, Palos Hill, IL 60465. Government Medical (India) 1973. Solo, partnership, group. Available 1981.

Harvey Schoenbrum, M.D., 1249 Park Avenue, Apt. 14-A, New York, NY 10029. Pittsburgh 1976. Board eligible. Group, partnership. Available July 1981.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available June 1981.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available July 1981.

Robert D. Zimmerman, M.D., 206 Friar Lane, Clifton, NJ 07013. Chicago Rush-Presbyterian. Board eligible. Partnership, solo, group. Available July 1981.

A peripheral vasodilator

for treatment of
**leg cramps
cold feet
tinnitus
discomfort on
standing**

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	.....300 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	.....250 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	.....100 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



LETTERS TO THE JOURNAL

Retired Physicians

October 29, 1980

Dear Dr. Krosnick:

The retirement of a physician can be disastrous. He topples from the peak of a grand career to the earthly dung below. This is especially true when he retires to a new area. His relationships with strange physicians are well illustrated in the recent book called *Heart Sounds*.

The worst place for a retired physician to settle is in an area which attracts senior citizens exclusively. This is particularly true of California or Florida. In these locations he is ignored by hospital administrators and his professional peers. As a patient in the hospital the nurses pay less attention to him than to the average patient.

The most ludicrous experiences are with retired non-medical people who are in the age group of sixty-five plus. Most of them are in the plus age group with various ailments, primarily cardiovascular.

Invariably when I'm with a group of retired men, 50 percent have had bypass operations, 50 percent have had prostatectomies and 25 percent have had both operations. Their discussions usually center around doctors, hospitals and the high cost of medical care. The final discussion becomes personal as each man recounts his ailment and operation step by step. As a retired physician, I am rarely asked for an opinion on any medical subject.

A typical discussion goes as follows: First acquaintance: "Last year I had a bypass—in fact two bypasses. A friend of mine who is a plumber told me that I should have had a pacemaker instead of a bypass operation." I spoke up without being asked. "Did you have an angio-?" But before I could complete my question, I was cut off by another neighbor, who promptly approved the criticism of the plumber. A few seconds later I heard a voice behind me. "I had a similar experience. A few years ago I had an operation on my neck after I had a little stroke. I don't know what my neck had

to do with my brain." I was about to tell them that he probably had a thrombosis of the carotid artery but someone else beat me to the punch. "You had a large thyroid which was pressing on your brain, so the surgeon had to cut out the thyroid gland." I had no opportunity for a rebuttal because the shuffle board champion of our apartment complex summarized the whole discussion. "An article in 'Readers Indigestion' recommends that after a heart attack a man should jog ten miles a day." This final remark prompted most of the men to reach for their *Wall Street Journal* and the rest rose from their chairs and left. I retrieved my *Playboy Magazine* from under my chair and studied the beautiful results of normal female hormones.

(signed) Max Magnes, M.D.

Ventnor Foundation

November 10, 1980

Dear Doctor:

As one approaches 82 he tends to clear out his files and throw away things that he wonders why he ever kept.

But there is one thing in the history of New Jersey Medicine that I am proud of and think the profession in New Jersey could reflect on with credit.

The enclosures [brochures on the Ventnor Foundation] may or may not be of interest to you and *The Journal* and the physicians of New Jersey. If not, throw them away. The hospitals of New Jersey have done a good job of educating and training in this program of foreign-educated doctors. You may count the achievements, professional and otherwise of the Alumni of the Ventnor Foundation and the New Jersey Hospitals as a yardstick of successful contribution of the total picture of medical care.

I need no ego support so please don't think that. I have been awarded the Ill Medal, honorary degrees from Rutgers and Swarthmore, the University of Cologne and Marburg. I am president, secretary/typist, file clerk, janitor of the

Ventnor Foundation. I do feel that the VF, a manifestation of private physicians and organized medicine in New Jersey unselfishly contributing to the medical care, one-on-one diplomacy, and waging peace through brotherhood, might merit a word. There is so much media criticism of our profession as materialistic, lacking in humanism and compassion.

Please don't think me crass but this letter and these enclosures are all I am prepared to render. I do not intend to write a history, an essay or a paragraph on the VF for any publication.

(signed) Hilton S. Read, M.D.

Nuclear War

November 18, 1980

Dear Dr. Krosnick:

Thank you for sending me a copy of the October, 1980, issue of *The Journal of the Medical Society of New Jersey*.

I certainly appreciate knowing your thoughts about the importance of preventing a nuclear war. Also, I share your deep concern about the extremely serious medical consequences of a nuclear weapons exchange between the Soviet Union and the United States. I have read your editorial regarding the incredible medical problems that would most likely result from a nuclear attack on a large metropolitan area with a great deal of interest.

As you may know, I have consistently opposed those policies that might aggravate nuclear proliferation problems. Moreover, I have supported earlier nuclear arms limitation agreements and I will continue to support the SALT process in the months and years to come.

Again, thank you for taking the time to bring your editorial and open letter to President Carter and Chairman Brezhnev to my attention. It is always helpful to me in my deliberations to have the benefit of such information.

With best wishes,

(signed) Harrison A. Williams
US Senator, New Jersey

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Feb.

- 7 **Clinical Anesthesia 1981**
8 a.m.-4 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 11 **Anesthesia for Various Myopathies**
8-9:30 p.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

Mar.

- 11 **Perinatal Pharmacology**
8-9:30 p.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
- 20- **Postgraduate Anesthesia Seminar**
- 22 Hyatt House, Cherry Hill
(*NJ State Society of Anesthesiologists and AMNJ*)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Feb.

- 3 **Colitis**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 3 **Diabetes**
2 p.m.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)
- 4 **Topic to be announced**
6:30 p.m.—The Manor, West Orange
(*AMNJ*)
- 4 **Abdominal Ultrasonography**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 4 **Endocrine Factors in Renal Disease**
6 p.m.—Holiday Inn, Evergreen Place, East Orange
(*The Society of Nephrology and AMNJ*)
- 4 **Evaluation of the Thyroid Nodule**
1:30-2:30—Rutgers Community Health Plan, 57 U.S. Highway #1 and Rt. 18, New Brunswick
(*Rutgers Community Health Plan and AMNJ*)

- 4 **Malignancies of the Upper Gastrointestinal Tract**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 4 **Thyroid Diseases**
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 4 **Treatment of Alcoholism**
- 18 **Abnormal Gait in Children**
9-11 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
- 4 **Fluid and Electrolyte Imbalance**
1 p.m.—Christ Hospital, Jersey City
(*AMNJ*)
- 4 **Transfusion Therapy**
11:30 a.m.—Rahway Hospital
(*AMNJ*)
- 4 **Monthly Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ*)
- 4 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(*AMNJ*)
- 4 **Exercise Electrocardiography**
- 25 **Chronic Hepatitis**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(*Dover General, Riverside, and St. Clare's Hospitals and AMNJ*)
- 4 **Internal Medicine and Therapeutics**
- 11 9-11 a.m.—Roosevelt Hospital, Menlo
- 18 Park
- 25 (*Middlesex General Hospital and AMNJ*)
- 4 **Fluid and Electrolyte Imbalance**
- 11 **Medical Lecture Series**
- 18 1-3 p.m.—Christ Hospital, Jersey City
- 25 (*Christ Hospital and AMNJ*)
- 4 **Endocrine Conferences**
- 11 3:30-5 p.m.—Rotates between Newark
- 18 Beth Israel Medical Center, College
- 25 Hospital, Newark and VA Medical Center, East Orange
(*AMNJ*)
- 4 **Medical Lecture Series**
- 11 1-2:30 p.m.—VA Medical Center, Lyons
- 18 (*VA Medical Center and AMNJ*)
- 25
- 5 **Medical Grand Rounds**
9:30 a.m.-11 a.m.—Newark Beth Israel Medical Center
(*AMNJ*)
- 5 **Joint Neurosurgery ENT Conference**
4-5:30 p.m.—NJ Medical School, Newark
(*CMDNJ*)
- 5 **Immunology '81**
- 12 4-6 p.m.—Institute for Medical Research Copewood St., Camden
(*Inst. for Medical Research and AMNJ*)

- 6 **Medical Grand Rounds**
11:30-1 p.m.—College Hospital, Newark
(*AMNJ*)
- 6 **Renal Conference in Nephrology**
- 20 2-3:15 p.m.—College Hospital, Newark
(*Nephrology Society of NJ and AMNJ*)
- 10 **Pigmentation Problems**
8 p.m.—Schering Corporation, Kenilworth
(*New Jersey Dermatological Society and AMNJ*)
- 10 **The Patient with Joint Symptoms**
- 24 **Diabetes Mellitus**
12 noon-2 p.m.—West Jersey Hospital, Camden
(*West Jersey Hospital*)
- 11 **Chronic Renal Failure in Geriatric Patients**
2 p.m.—John E. Rannels Hospital, Berkeley Heights
(*AMNJ*)
- 11 **Cardiology Conferences**
- 25 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(*CMDNJ, Somerset County Heart Association and AMNJ*)
- 12 **Topic to be announced**
7:30-9:30 p.m.—Overlook Hospital, Summit
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 17 **Hypertension**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 17 **Newer Concepts in Hepatitis**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 18 **Dermatological Conference**
6-8 p.m.—Rutgers Community Health Plan, 57 U.S. Highway #1 and Rt. 18, New Brunswick
(*CMDNJ and AMNJ*)
- 18 **Asthma Fatalities**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)
- 18 **Endocrinology/Metabolism: Thyroid Diseases**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(*Columbus Hospital and AMNJ*)
- 18 **Kidney Stones**
1:30-2:30 p.m.—Rutgers Community Health Plan, 57 U.S. Highway #1 and Rt. 18, New Brunswick
(*Rutgers Community Health Plan and AMNJ*)
- 20 **Leukemia**
12 noon—Freehold Area Hospital
(*AMNJ*)

PHILADELPHIA G.I. GROUP

Presents

"COMMON G.I. PROBLEMS EMPHASIZING MANAGEMENT"

March 7, 1981

MARRIOTT MOTOR HOTEL

City Line Ave. at Monument Rd., Philadelphia, Pa.

8:30- 9:00 REGISTRATION AND COFFEE

9:00-10:30 THE AGING GUT—Mod.: Stanley H. Lorber, M.D.

H. Clearfield—Ca Detection

B. Frank—Divertic. Dis.

R. Fisher—Chest Pain GI Orig.

W. Rubin—Constipation

10:30-10:45 COFFEE

10:45-12:15 PEPTIC ULCER—Mod.: O.D. Kowlessar, M.D.

F. Brooks—H₂ Inhibitors

W. Lipshutz—Gastric Ulcer

S. Cohen—Duodenal Ulcer

W. Mahood—G.I. Bleeding

12:15- 1:30 LUNCHEON

1:30- 3:00 HEPATITIS UPDATE—Mod.: Martin Black, M.D.

R. Meyerson—A & non A non B

R. Soloway—Chronic Active

J. Senior—Drug Induced

J. Watkins—B

3:00- 3:15 COFFEE AND COKE

3:15- 4:45 INFLAMMATORY BOWEL DISEASE—Mod.: Henry J. Tumen, M.D.

E. Cohn—Ischemic Colitis

F. Goldstein—Crohn's

J. Deren—Infectious Diarr.

J. Roth—Ulcerative Colitis

American Academy of Family Physicians

6 hours

Pennsylvania Academy of Family Physicians

6 hours

AMA Physician's Recognition Award Category I

6 hours

American College of General Practitioners in

Osteopathic Medicine and Surgery—Class II

6 hours

Registration: \$50.00

Physicians in Training: \$15.00

Luncheon and Syllabus Included

G.I. Assistants: \$15.00

MAIL CHECK PAYABLE TO "PHILADELPHIA G.I. GROUP" TO:

Norman N. Cohen, M.D., P.C.

Program Chairman

Mercy Catholic Medical Center

Darby, Pennsylvania 19023

- 21 **Hodgkin's Disease**
8-10 a.m.—Newcomb Hospital,
Vineland
(*Newcomb Hospital*)
- 25- **Advanced Cardiac Life Support Course**
26 9 a.m.-5 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- Mar.
- 4 **Ninth Joint Conference**
All Day—Coachman Inn, Cranford
(*NJ Thoracic Society and NJ Chapter,
American College of Chest Physicians*)
- 4 **Breast Cancer**
10:30 a.m.-12 noon—St. Mary's
Hospital, Passaic
(*AMNJ*)
- 4 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—VA Medical Center,
East Orange
(*AMNJ*)
- 4 **Monthly Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section, AMNJ*)
- 4 **Antibiotics in Office-Based Practice**
9-11 a.m.—West Jersey Hospital,
Voorhees
(*West Jersey Hospital*)
- 4 **Autoimmune Disease**
11:30 a.m.-1 p.m.—Rahway Hospital
(*Rahway Hospital and AMNJ*)
- 4 **Endocrine Conferences**
11 3:30-5 p.m.—Rotates between Newark
18 Beth Israel Medical Center, College
25 Hospital, Newark and VA Medical
Center, East Orange
(*AMNJ*)
- 4 **Internal Medicine and Therapeutics**
11 9-11 a.m.—Roosevelt Hospital, Menlo
18 Park
25 (*Middlesex General Hospital and AMNJ*)
- 4 **Medical Lecture Series**
11 1-3 p.m.—Christ Hospital, Jersey City
18 (*Christ Hospital and AMNJ*)
25
- 4 **Medical Lecture Series**
11 1-2:30 p.m.—VA Medical Center, Lyons
18 (*VA Medical Center and AMNJ*)
25
- 5 **Medical Grand Rounds**
9:30-11 a.m.—Newark Beth Israel
Medical Center
(*AMNJ*)
- 5 **Immunology '81**
12 4-6 p.m.—Institute for Medical Research
19 Copewood St., Camden
26 (*Institute for Medical Research and
AMNJ*)
- 6 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—College Hospital,
Newark
(*AMNJ*)
- 6 **Renal Conferences in Nephrology**
20 2-3:15 p.m.—College Hospital, Newark
(*Nephrology Society of NJ and AMNJ*)
- 7 **Rehabilitation Following Stroke**
8-10 a.m.—Newcomb Hospital,
Vineland
(*Newcomb Hospital*)
- 10 **Urinary Tract Infections**
24 Hemo and Peritoneal Dialysis
12 noon-2 p.m.—West Jersey Hospital,
Camden
(*West Jersey Hospital*)
- 10 **Antibiotics for Everyday Use**
8-10 p.m.—Schering Corporation,
Kenilworth
(*NJ Dermatological Society and AMNJ*)
- 11 **Neuroses in Office Practice**
- 25 **Clinical Approach to the Thyroid Nodule**
9:30-11:30 a.m.—St. Clare's Hospital,
Denville
(*Dover General, Riverside, and Saint
Clare's Hospitals and AMNJ*)
- 11 **Cardiology Conferences**
25 3:30-5:30 p.m.—Middlesex General
Hospital, New Brunswick
(*CMDNJ, Somerset County Heart
Association and AMNJ*)
- 14 **Angiotensin Receptors**
4:30-5:30 p.m.—St. Barnabas Medical
Center, Livingston
(*St. Barnabas Medical Center and
AMNJ*)
- 16 **Antibiotic Therapy**
12:30-1:30 p.m.—West Hudson
Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 18 **Management of Hepatitis**
11:30 a.m.—Columbus Hospital,
Newark
(*AMNJ*)
- 18 **Asbestos-Related Disease**
11:30 a.m.-1 p.m.—VA Medical Center,
East Orange
(*VA Medical Center and AMNJ*)
- 18 **Gastrointestinal Fistulae**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 18 **Dermatological Conference**
6-8 p.m.—Rutgers Community Health
Plan, 57 U.S. Highway #1 and Rt. 18,
New Brunswick
(*CMDNJ and AMNJ*)
- 19 **Problems in Occupational Health of
Concern to Practicing Physicians**
5-6:30 p.m.—Somerset Medical Center,
Somerville
(*Somerset Medical Center and AMNJ*)
- 21 **Clinical Endocrinology**
9 a.m.-4 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 24 **Topic to be announced**
7:30-9 p.m.—Coachman Inn, Cranford
(*NJ Blood Club and AMNJ*)
- 25 **Regional Hospital Meeting**
8-10 p.m.—Holy Name Hospital,
Teaneck
(*NJ Gastroenterological Society and
AMNJ*)
- 25- **Advanced Cardiac Life Support Course**
26 9 a.m.-5 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- NEUROLOGY/PSYCHIATRY**
- Feb.
- 2 **Ugly Duckling**
8-10 p.m.—39 Crescent Ave., Passaic
(*Essex Psychiatric Seminars and AMNJ*)
- 2 **Neuroscience Conferences**
9 11:30 a.m.-12:30 p.m.—Bergen Pines
16 County Hospital, Paramus
23 (*Bergen Pines County Hospital and
AMNJ*)
- 3 **Psychiatric Case Conferences**
10 7:30-9:30 a.m.—Trenton Psychiatric
17 Hospital
24 (*Trenton Psychiatric Hospital and
AMNJ*)
- 4 **Personality Traits Leading to Cult
Readiness**
- 18 **Movement Disorders**
1:30-3 p.m.—Community Mental Health
Center—NJ Medical School
(*CMDNJ and AMNJ*)
- 4 **Treatment of Different Populations of
Drug Abuse**
- 11 **Psychosomatic Medicine**
- 25 **The Nuclear Family in Crisis**
1-3 p.m.—Ancora Psychiatric Hospital,
Hammononton
(*Ancora Psychiatric Hospital and AMNJ*)
- 4 **Treatment of Speaking Anxiety**
- 18 **The Psychiatric Emergency**
- 25 **New Advances in Psychopharmacology**
1-3 p.m.—Ancora Psychiatric Hospital,
Hammononton
(*Ancora Psychiatric Hospital and AMNJ*)
- 4 **Child Psychiatry Case Conference and
Lecture**
- 11 **Lecture**
- 18 8:30-10:30 a.m.—Trenton Psychiatric
25 Hospital
(*Trenton Psychiatric Hospital and
AMNJ*)
- 5 **Psychopharmacology and the Geriatric
Patient**
- 12 **Case Presentation**
- 19 **Brief Psychotherapy Techniques**
- 26 **Brief Psychotherapy Techniques**
11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and
AMNJ*)
- 7 **Teaching of Family Therapy**
- 14 **Practical Aspects of Family Therapy**
- 28 **Research in Family Therapy**
12-1:30 p.m.—Carrier Foundation,
Belle Mead
(*Carrier Foundation and AMNJ*)
- 11 **Parkinson's Disease**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 12 **The Latency Period in Girls**
8:30-11 p.m.—St. Barnabas Hospital,
Livingston
(*NJ Psychoanalytic Society and AMNJ*)
- 18 **Lithium: Other Uses and Causes**
1:30 p.m.—Trenton Psychiatric Hospital
(*AMNJ*)
- 19 **Family Therapy for Psychosomatic
Disorders**
5-6:30 p.m.—Somerset Medical Center,
Somerville
(*Somerset Medical Center and AMNJ*)
- 20 **Hypnosis**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(*Carrier Foundation and AMNJ*)
- Mar.
- 2 **Add Self to Wife and Mother**
8-10 p.m.—111 Ridgewood Ave., Glen
Ridge
(*Essex Psychiatric Doctors Seminars and
AMNJ*)
- 2 **Neuroscience Conferences**
- 9 11:30 a.m.-12:30 p.m.—Bergen Pines
- 16 **County Hospital, Paramus**
- 23 (*Bergen Pines County Hospital and
AMNJ*)
- 3 **Psychiatric Case Conferences**
- 10 7:30-9:30 a.m.—Trenton Psychiatric
- 17 **Hospital**
- 24 (*Trenton Psychiatric Hospital and
AMNJ*)
- 31 **AMNJ**

Recent Progress in Clinical Endocrinology

MARCH 21, 1981

College of Medicine & Dentistry
of New Jersey-
New Jersey Medical School,
Department of Medicine
Newark, N.J.

Category I credit offered. A.O.A. accredited.
A.A.F.P. applied for.

Objective: This course is intended to aid physicians practicing general internal medicine and/or endocrinology in keeping abreast of the major recent advances in the fields of endocrinology and metabolic medicine. Adequate background will be provided for those physicians who are not currently in an academic environment.

REGISTRATION FEE: \$60.

For further information please contact:
Patricia Sarles, M.S.
CMDNJ-Office of Continuing Education
100 Bergen Street
Newark, N.J.
(201) 456-4267

4	Ongoing Child Psychiatry Case Conference and Lecture 8:30-10:30 a.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)	(CMNDNJ and AMNJ)	7	Genetic Counseling—Who Needs It? 8-10 a.m.—Newcomb Hospital, Vineland (Newcomb Hospital)	12	Home Talent 7:30-9:30 p.m.—St. Barnabas Medical Center, Livingston (NJ Institute of Ultrasound in Medicine and AMNJ)
5	Brief Psychotherapy Techniques		11	Pulmonary Diseases in Obstetrics 8-9 a.m.—Garden State Community Hospital, Marlton (Garden State Community Hospital and AMNJ)	17	Radionuclide Myocardial Imaging 12 noon—St. Mary's Hospital, Orange (AMNJ)
12	Case Presentation		26	Ovarian Carcinoma 4-5:30 p.m.—West Jersey Hospital, Voorhees (West Jersey Hospital)	18	Dinner Meeting 6:30 p.m.—The Manor, West Orange (Radiotherapy Section, AMNJ)
19	Family Therapy for the Treatment of Children		Mar.		19	Visiting Professorship Program 1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston (St. Barnabas Medical Center)
26	Family Therapy for the Treatment of Adolescents 11 a.m.-12 noon—Greystone Park Psychiatric Hospital (Greystone Park Psychiatric Hospital and AMNJ)		4	Cervical Carcinoma in Young Women 6-7 p.m.—NJ Medical School, Newark (CMDNJ and AMNJ)	19	Radiology of Soft Tissues 8 p.m.—Hospital Center at Orange (Radiological Society of NJ and AMNJ)
6	Psychiatric Lecture 1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)		26	High Risk Obstetrical Patients 4-5:30 p.m.—West Jersey Hospital, Voorhees (West Jersey Hospital)	GENERAL SURGERY	
6	DSM: Practical Review		PATHOLOGY		Feb.	
13	Differential Diagnosis of Fugue-like States		Mar.		3	Soft Tissue Sarcomas
27	Differentiating Manic-Depressive Illness and Schizophrenia 12 noon-1:30 p.m.—Carrier Foundation, Belle Mead (Carrier Foundation and AMNJ)		24	Cytologic Diagnosis by Fine-Needle Aspiration 8 p.m.—Warren Hospital, Phillipsburg (AMNJ)	24	Radionuclides in Surgical Diagnosis 5-6 p.m.—Rutgers Medical School, Piscataway (CMDNJ and AMNJ)
6	Psychological Testing and Basics of Statistics 2:45-3:45 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)		PEDIATRICS		3	Tumor Conferences
13	Neuronatomy/Neuropathology and Clinical Neurology 1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)		Feb.		10	12 noon—Morristown Memorial Hospital
20	2:45-3:45 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)		5	Hypertension in Children 9 a.m.—Freehold Area Hospital (AMNJ)	17	Hospital
27	Community Psychiatry 1:30-2:30 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)		20	Microscopic Hematuria in Children 7:45-9:15 a.m.—West Jersey Hospital, Voorhees (West Jersey Hospital)	24	(Morristown Memorial Hospital and AMNJ)
6	Neurology 11 a.m.—Greystone Park Psychiatric Hospital (AMNJ)		Mar.		14	High Risk Surgery 9 a.m.—St. Peter's Medical Center, New Brunswick (AMNJ)
13	Joint Meeting with the NJ Psychiatric Association 8:30-11 p.m.—Ramada Inn, Clark (NJ Psychoanalytic Society and AMNJ)		16	Nephrotic Syndrome 12 noon-1 p.m.—Mountainside Hospital, Montclair (Mountainside Hospital and AMNJ)	16	Breast Carcinoma 12:30-1:30 p.m.—West Hudson Hospital, Kearny (West Hudson Hospital and AMNJ)
19	Social, Cultural and Intrapsychic Conflict in a Professional Woman 12 noon-1 p.m.—Carrier Foundation, Belle Mead (Carrier Foundation and AMNJ)		20	I.V. Isuprel in the Treatment of Children 7:45-9:15 a.m.—West Jersey Hospital, Voorhees (West Jersey Hospital)	19	Deep Vein Thromboses 7:30-9 a.m.—West Jersey Hospital, Voorhees (West Jersey Hospital)
20	Neurology 12 noon—Freehold Area Hospital (AMNJ)		RADIOLOGY		Mar.	
21	Spinal Cord Syndrome 8-10 a.m.—Newcomb Hospital, Vineland (Newcomb Hospital)		Feb.		3	Tumor Conferences
24	Immunology 11 a.m.—Greystone Park Psychiatric Hospital (AMNJ)		11	Radiology Meeting 7:45-10:15 p.m.—Morristown Memorial Hospital (Radiological Society of NJ)	10	12 noon—Morristown Memorial Hospital
OBSTETRICS/GYNECOLOGY			19	Topic to be announced 8 p.m.—Hospital Center at Orange (Radiological Society of NJ and AMNJ)	17	Hospital
Feb.			25	Radiation Therapy of Cancer of the Uterus 11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark (Columbus Hospital and AMNJ)	24	(Morristown Memorial Hospital and AMNJ)
4	Distinguished Lectures in Obstetrics/Gynecology 6-7 p.m.—NJ Medical School, Newark		26	Visiting Professorship Program 1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston (St. Barnabas Medical Center)	12	Tumor Conference 12 noon-1 p.m.—West Hudson Hospital, Kearny (West Hudson Hospital and AMNJ)
			Mar.		19	Diverticulitis 7:30-9 a.m.—West Jersey Hospital, Voorhees (West Jersey Hospital)
			11	Case Presentations 7:45-10:15 p.m.—Morristown Memorial Hospital	24	Thyroid Biopsies 8-10 p.m.—Englewood Club, Englewood (Englewood Surgical Society and AMNJ)
					SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastic, and Vascular Surgery)	
					Feb.	
					5	Joint Neurosurgery ENT Conference
					12	Neurosurgery-Plastic Surgery Conference
					19	Neurosurgery Orthopedic Conference
					26	Neurosurgery Conference 4-5:30 p.m.—NJ Medical School, Newark (CMDNJ)

- 24 **Silicone in Hand Surgery**
8-10 p.m.—Englewood Club, 115 East
Palisade Ave., Englewood
(*Englewood Surgical Society and AMNJ*)

- Mar.
Sixth Annual Orthopaedic Symposium
27 12 noon-4 p.m.—Rutgers Medical
School
28 8 a.m.-4 p.m.—Rutgers Medical School,
Piscataway
(*NJ Orthopaedic Society and AMNJ*)

MISCELLANEOUS

- Feb.
4 **Legislation and the Handicapped**
4:15-5:15 p.m.—Kessler Institute for
Rehabilitation, West Orange
(*Kessler Institute and AMNJ*)

OBITUARIES

Dr. Ralph M. L. Buchanan

Ralph M. L. Buchanan, M.D., the 169th President of the Medical Society of New Jersey (1961-1962), died suddenly in Warren Hospital, Phillipsburg, on November 20, 1980, of a heart ailment. A native of Pennsylvania, born in 1907, Dr. Buchanan was graduated from Hahnemann Medical College in 1933 and pursued a career in surgery, taking graduate work at Abington Memorial Hospital, Abington, Pennsylvania and New York University-Bellevue Medical Center Postgraduate School. He was a Fellow of the American College of Surgeons, of the International College of Surgeons, and a member of the Royal Society of Physicians in England, and of the Academy of Medicine of New Jersey. Dr. Buchanan had been on the surgical staff of the Warren Hospital all of his career. He was interested in industrial medicine and had served as the medical director of Ingersoll-Rand for many years. He had been alternate delegate to the American Medical Association for four years and was state judicial councilor for the first district for three terms. On the county level Dr. Buchanan had served two terms as president of the Warren County Medical Society and was its secretary for 30 years. He was a member of the State Board of Medical Examiners for 17 years and its president

for seven. Dr. Buchanan was the only physician to serve concurrently as president of the Medical Society of New Jersey and president of the State Board of Medical Examiners. He had been a member of the executive committee of the New Jersey Society of Surgeons and a member of the board of trustees of the Medical-Surgical Plan of New Jersey. During World War II, Dr. Buchanan served as a surgeon in the Marine Corps in the Pacific theater, attaining the rank of lieutenant commander.

Dr. Norman L. Cash

At the untimely age of 54, Norman L. Cash, M.D., of South Plainfield, died on November 8. Born in New York City, Dr. Cash was graduated from the Medical College of the University of Amsterdam in The Netherlands in 1956. After internship at the Muhlenberg Hospital, he pursued a residency in obstetrics and gynecology at Fordham University Hospital in the Bronx. He established a practice in Plainfield and had been on the staff at Muhlenberg Hospital there and also was affiliated with John F. Kennedy Medical Center in Edison. Dr. Cash was board certified in his specialty and a Fellow of the American College of Obstetricians and Gynecologists.

Dr. Stanton H. Davis

The former chief of obstetrics at Muhlenberg Hospital in Plainfield, Stanton H. Davis, M.D., died on October 20 in Lubbock, Texas. A native of New York State, Dr. Davis was graduated from Yale Medical College in 1920 and practiced in Plainfield for 35 years before retiring in 1959 to Cambridge, Maryland. He had been living in Lubbock for about five years. He was a Fellow of the American College of Surgeons and, in addition to his appointment at Muhlenberg Hospital, he was on the staffs at Somerset Hospital in Somerville and Rahway Memorial Hospital. Dr. Davis was 86 years old at the time of his death.

Dr. Runkle F. Hegeman

Notice just has been received of the death on May 24, 1979 in Cambridge, Maryland of Runkle F. Hegeman, M.D., formerly of Somerville and a member of the Somerset County Medical Society. Dr. Hegeman was graduated from Johns Hopkins University Medical School in 1910 and pursued a career in general surgery. He had been on the staff at Somerset Hospital in Somerville, and was a member of the prestigious New Jersey Society of Surgeons. Dr. Hege-

man had been active in county society affairs, having served two terms as president of his county society and twenty years as its treasurer. He also was active in civic affairs, serving on the Somerville board of health for twenty-five years and as borough physician to the township for a like period of time. In 1960 Dr. Hegeman was a recipient of MSNJ's Golden Merit Award indicating fifty years of practice. He was 95 years old at the time of his death.

Dr. Harold J. Muendel

Harold J. Muendel, M.D., of Basking Ridge, a member of our Morris County component, died on November 16 at Morristown Memorial Hospital. A native of Union City, born in 1908, Dr. Muendel was graduated from Long Island College of Medicine in 1935 and pursued a career in general surgery. He was a Fellow of the American College of Surgeons and had been chief of the surgical service at the Veterans Administration facility at Lyons and on the staff at Morristown Memorial Hospital before his retirement in 1975. Dr. Muendel had been physician for the Bernardsville Township school system and consultant to the town's board of health and the tuberculosis control agency. During World War II, Dr. Muendel served with the medical department of the AUS, attaining the rank of lieutenant colonel.

Dr. Morris Parmet

The former president of the New Jersey Mental Health Association, Morris Parmet, M.D., died on November 22, 1980 in Princeton Medical Center after a long illness. Born in 1913, Dr. Parmet was graduated from Jefferson Medical College in 1939 and pursued graduate training in psychiatry at the Veterans Administration Hospital in Coatesville, Pennsylvania, becoming board certified in psychiatry and neurology. His particular interest was child and adolescent psychiatry, and he had been affiliated with the Carrier Clinic in Belle Mead, the Medical Center at Princeton, and Hunterdon Medical Center in Flemington. He had held teaching appointments at New York University Medical School, the Einstein Medical School (Bronx) and was associate clinical professor of psychiatry at Rutgers Medical School. Dr. Parmet was a Fellow of the American Psychiatric Association and of the Academy of Child Psychiatry.

Dr. Thomas L. Pasquale

On October 18, Thomas L. Pasquale, M.D., a member of our Essex County component, died after a brief illness. A native of Newark, born in 1917, Dr. Pasquale was graduated from Georgetown University Medical School in 1943 and established a practice in general medicine in Orange. He subsequently took graduate training in obstetrics and gynecology and became board certified in that specialty. He was affiliated with Presbyterian, Martland, and St. Michael's Hospitals in Newark, and Clara Maass Memorial Hospital in Belleville. In recent years he had been employed by Hoffmann-La Roche in Nutley and was not engaged in private practice.

Dr. John H. Rowland

At the grand old age of 90, an emeritus member of our Middlesex County component, John Henry Rowland, M.D., of New Brunswick, died on November 18. Dr. Rowland was graduated from New York University Medical College in 1919 and pursued a career in internal medicine with special interest in cardiovascular diseases. He was board certified in his specialty and a Fellow of the American College of Cardiology and of the American College of Physicians. He had been on the staff at Middlesex General and St. Peter's Hospitals in New Brunswick and Roosevelt Hospital in Metuchen. He had been a member of the State Board of Medical Examiners for many years and served a term as its president in 1943. He was active in organized medicine and had served as chairman of MSNJ's Committee on Cardiovascular Diseases. In 1969 Dr. Rowland was a recipient of MSNJ's Golden Merit Award in honor of his fifty years of practice.

Dr. Louis A. Schneider

On November 12, 1980, Louis A. Schneider, M.D., a member of our Hudson County component, died at his home in Lakewood where he still was engaged actively in the practice of medicine. A native of New York City, born in 1901, Dr. Schneider received his medical degree from Vanderbilt University in 1928 and pursued a career in the practice of obstetrics and gynecology. He was a Fellow of the American College of Obstetricians and Gynecologists and had been on the staff at North Hudson Hospital in Weehawken, where he served as president of the staff and chief of the

department of obstetrics and gynecology, and at the Margaret Hague Maternity Hospital in Jersey City. Dr. Schneider had retired to Lakewood in the early 1970s and maintained a limited general practice in the retirement community of Leisure Village East. He was a recipient of MSNJ's Golden Merit Award in 1978, honoring his 50 years as a physician.

Dr. Leon A. Smith

Leon A. Smith, M.D., a member of our Passaic County component, died on November 9 in St. Mary's Hospital, Passaic. A native of New Jersey, Dr. Smith was graduated from Columbia University's College of Physicians and Surgeons in 1928 and practiced general medicine and surgery in Passaic for fifty years, receiving MSNJ's Golden Merit Award in recognition of that accomplishment in 1978. His avocation was music, and he was an accomplished cellist, a member of the string quartet that included the poet William Carlos Williams. As a young man he was a renowned basketball player, having been elected to the National Basketball Hall of Fame for his participation in the Passaic High School team that won more than 150 consecutive games between 1919 and 1925. He also played semiprofessional baseball while attending medical school. Dr. Smith was 78 years old at the time of his death.

Dr. Alvan Spencer

Word has been received of the death on January 23, 1976 of Alvan Spencer, M.D., formerly of Morris County, where he practiced otolaryngology and was affiliated with the Dover General Hospital. A native of New Jersey, born in 1890, Dr. Spencer was graduated from Long Island University College of Medicine in 1913. He has been retired for quite some time and was living in West Palm Beach, Florida.

Dr. Ralph J. Vreeland

A member of our Passaic County component, Ralph J. Vreeland, M.D., formerly a practitioner in Paterson and Ridgewood, died on November 13 after a long illness. Born in 1889, Dr. Vreeland was graduated from the University of Maryland School of Medicine in 1911 and pursued a career in otolaryngology. Since retirement in 1960 he had been living in Wyckoff, New Jersey.

BOOK REVIEWS

Sexual Consequences of Disability

Alex Comfort, Ed. Philadelphia, George F. Stickley, 1978. Pp. 296. Illustrated. (no price given)

This volume contains a number of excellent essays on different aspects of sex and disability. The basic principles of the field are repeatedly and eloquently stated, namely that the disabled are still human beings with the same (or greater) needs as the rest of us for the affection, warmth and intimacy that sex can provide, that their needs too often are neglected by health professionals who are uneasy and embarrassed by discussion of sexual matters, and that we all can learn much from the disabled about how to deal with sexual problems. In addition, a great deal of specific information is provided about the needs of individuals with particular disorders. A couple of chapters describe interesting, ongoing research. Almost any practitioner will find material in this volume that will be useful to him and to his patients.

The book does have shortcomings. It is not tightly edited and tends to be uneven with considerable variations in style and eloquence. There is much unnecessary repetition, particularly in the chapters dealing with impotence, while other important topics, e.g., the value of vibrators to women who cannot find partners, are barely touched on. Throughout the book emphasis is on heterosexual, disabled individuals. The problems our society poses for those who are both disabled and homosexual are dealt with inadequately. Most authors emphasize that satisfactory sex does not require that a penis be inserted in a vagina, but the two urologists clearly feel that an erect penis is essential for male satisfaction. A discussion of such differing opinions could be most enlightening, but when they are merely stated without comment, the average reader can be confused.

A more fundamental problem is inherent in the subject. Most physicians realize that their patients have sexual needs, but they have real difficulty overcoming their own embarrassment and reluctance to deal openly with such matters. No book can fully alleviate such

discomfort; one of the best is Dr. Comfort's earlier treatise, *The Joy of Sex*.

In summary, this volume contains a lot of useful information. It should be in every hospital library, readily available for reference, where I hope the binding holds together better than it did in the volume I read.

Richard J. Cross, M.D.

Basic and Clinical Immunology, 3rd Ed.

H.H. Fudenberg, D.P. Stites, J.L. Caldwell, and J.V. Wells. Los Altos, CA, Lange, 1980. Pp. 782. Illustrated. (\$17.50)

This is a firmly bound, soft-cover book with excellent printing and many illustrations. The latter include line drawings and black and white photomicrographs. The paper is of such quality that the photographs are clear and hence informative (a finding being seen less frequently these days).

There are four editors and fifty-three authors; the latter representing all specialties, subspecialties and variants thereof in clinical and laboratory medicine. These range from basic biochemists to those who are blood bank directors.

The book is comprised of four sections with 44 chapters and an appendix and index. The appendix which includes a "Glossary of Terms and Acronyms and Abbreviations Commonly used in Immunology" is a true delight. The index of 53 triple-columned pages is most complete. The four sections are I. Basic Immunology; II. Immunobiology; III. Immunology Laboratory Tests; IV. Clinical Immunology. The first two chapters of Section I, "The Immune System and Overview" and "The Foundations of Immunology," plus the appendix, are worth the price of the book.

In the preface the editors express the hope that this will serve as a text for medical students, house officers, graduate students and practicing physicians. I completely agree and would put strong emphasis on its use by practicing physicians. Both basic and clinical immunology are now in their beginning stages and as more and more advances

are made it becomes more and more important that the practicing physician understands these beginnings. To one who is not working the field it may seem complex at first but my advice is just keep at it and soon new lights will begin to shine through. This is the book to turn on those new lights.

Hugh F. Luddecke, M.D.

Handbook of First Aid and Emergency Care.

Developed by the American Medical Association. Martha Ross Franks, New York, Random House, 1980. Pp. 234. Illus. (\$5.95)

This book should be in every home because of a special economic urgency as it concerns our health habits and sensible life styles. As individuals, each of us is better qualified than anyone else to act as the guardian of his health. One of the most effective ways the individual can combat this numbing inflation is to avoid the avoidable and prevent the preventable. This is the reason for the publication of this book. The book brings the most authoritative and useful information available on a wide range of health care subjects. It deals with those unexpected mishaps and misfortunes that from time to time befall nearly all of us. The subject matter is very well described in simple language understood by the nonprofessional person and well illustrated. The book is divided into two parts—Part I has eight general informational parts and Part II is designed for quick, easy access at the time of the emergency and includes step-by-step treatment of specific injuries and illnesses. The injuries and illnesses, such as broken bones, abdominal pain, heart attack, stroke, vomiting, and others, are listed in alphabetical order so they can be found quickly. When an emergency strikes, knowing what to do in the first few minutes before medical help arrives can mean the difference between life and death. This book is especially geared for home use and encompasses the widest range of physical problems people encounter—from broken bones to burns, from heart attacks to shock and childbirth.

Jack R. Karel, M.D.

DIRECTOR EMERGENCY MEDICINE

St. Francis Medical Center, a 483 bed Major Teaching hospital is seeking qualified candidate for Director, Dept. of Emergency Medical Services.

Minimum qualifications; Diplomate, Board of Emergency Medicine of; Board certification in a clinical speciality and the ability to obtain certification in Emergency Medicine within six years. Successful candidate, will also participate in the Medical Center's medical education programs and have limited clinical responsibilities.

Starting salary of \$70,000 to \$100,000 depending on professional credentials and level of experience in the practice of Emergency Medicine. Malpractice insurance and an excellent fringe benefit package provided.

St. Francis Medical Center is located in an established residential area of Trenton, NJ, within easy driving distance of Princeton, New York City and Philadelphia.

Mr. Robert Moonan
Chairman Search Committee
St. Francis Medical Center
601 Hamilton Ave.
Trenton, New Jersey 08629

SEEKING FACULTY MEMBER

The Department of Family Medicine of Cooper Medical Center, the Clinical Campus Hospital for CMDNJ-Rutgers Medical School at Camden is seeking a faculty member to develop and supervise the Family Medicine Undergraduate medical student curriculum for the class beginning at Cooper Medical Center in September, 1983. This will be a full-time salaried position. The individual must be Board Certified, eligible for a faculty appointment to the Rutgers Medical School and have training and experience in family practice, teaching and administration.

Send C.V. to: James Sobel, M.D., Dept. of
Family Medicine
Cooper Medical Center
One Cooper Plaza
Camden, N.J. 08103

CMDNJ-RMS/CMC are EO/AA Employees

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$16,100 to \$18,400 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

BSN NURSES U.S. NAVY NURSE PROGRAMS

Gain valuable experience in general nursing practice or take advantage of programs in pediatric nursing, OB/GYN, or your specialty. Explore the expanded role of nurse practitioner. Work toward a master's degree under our scholarship or tuition assistance programs.

A navy nurse enjoys the prestige and privileges of a Navy officer with benefits that include—30 days paid vacation per year/free medical & dental care/travel, and educational assistance.

for more information
TALK TO A NAVY NURSE
Phone LT. Mary Ellen Quinn at
(215) 564-3820 (collect)

INDUSTRIAL/EMERGENCY PHYSICIAN

We are seeking a physician to augment our staff in our Trenton industrial clinic. Opportunity for advancement. Salary competitive, merit increments. Excellent benefits include malpractice and CME allowance. No night or weekend duty. New Jersey license required. Send salary requirement and curriculum vitae to Box No. 225, c/o JOURNAL MSNJ.

NEW JERSEY—ANCORA

Immediate openings for New Jersey licensed Staff Psychiatrists in 100 bed JCAH and AMA Accredited Psychiatric Hospital. Affiliated with Temple University Hospital, Department of Psychiatry. Located 30 miles from Atlantic City and Philadelphia. Salary commensurate with training and experience from \$33,885 to \$50,435. Private practice after duty permitted. Liberal fringe benefits include Blue Cross, Blue Shield, and Life Insurance.

Write: Ancora Psychiatric Hospital
Box B
Hammononton, New Jersey 08037
or call
(609) 561-1700, Ext. 203

THINKING OF RETIRING?

MEDICAL DIRECTORSHIPS available, across the USA, any age physician. No fee, malpractice insurance paid, 35 hrs/wk, \$35, to \$40,000/yr., depending on location. List valid licenses, when able to relocate? Where? Please send resume, including telephone number to:

Fred V. Hrachovina, D.O.
1000 Second Avenue South
Minneapolis, Minnesota 55403

WANTED

For South Jersey Multi-speciality group internists:
Internists with sub-speciality training in endocrinology, peripheral vascular disease and pulmonary diseases.

Brachfeld Medical Associates
Rancocas Valley Hospital
Willingboro, N.J. 08046

NEEMA EMERGENCY MEDICAL —a professional association—

Emergency Medicine Positions—available with emergency physician group in Pa., N.Y., N.J., Va., W. Va., Md. and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical
Suite 400 or phone
399 Market Street in Pa., (215) 925-3511
Philadelphia, Pa. 19106 outside Pa., 800-523-0776

SEEKING OBSTETRICIAN AND ANESTHESIOLOGIST

Lovely southwestern climate, multispecialty group seeking obstetrician-Gynecologist and an Anesthesiologist. Substantial guarantee. Contact Talton L. Francis, El Paso Medical-Surgical Associates, Pa., 10301 Gateway West, El Paso, Texas 79925.

VIRGINIA

Primary care physician needed to join staff at growing practice in scenic Central Virginia. Enjoy well equipped facility, excellent staff, strong community support, guaranteed income, excellent linkages with hospitals and other providers in area with beautiful mountains, large lakes, and year-round mild weather. Locum tenens considered.

Contact: John Troidl, Administrator
Evington Medical Center
Evington, Virginia 24550
(804) 821-5000

PHYSICIANS

All specialties. Regularly scheduled hours, respectable salary, malpractice paid, free health/dental, 30 days paid vacation, many family benefits and more. Must qualify for commissioned officer in Navy Medical Corps. Send C.V. to Medical Programs Officer, 128 N. Broad St., Philadelphia, PA 19102 or call (215) 597-9680 or 564-3820.

CLASSIFIED ADVERTISEMENTS

PEDIATRIC ASSOCIATE—New Jersey Shore area, 1-1/2 hours to New York City and Philadelphia. Write Box No. 224, c/o JOURNAL MSNJ.

CARDIOLOGIST—B.E., American graduate, university trained, skilled in 2-D echo, all nuclear techniques. Seeks hospital based, specialty or multi-specialty practice. Available July 1981. Sheldon Eisenberg, 300 Community Drive, Bldg. 4/5, Apt. 3N, Manhasset, N.Y. 11030 (516) 627-7593.

PHYSICIAN—ER or Surg. experience for industrial practice. Elizabeth, N.J. Hours 9-3 daily. Call (201) 351-6170.

GENERAL SURGERY—Seeking General Surgery Group or Partnership Practice. Board eligible. General Surgery Residency, CMDNJ. M.D. degree., Universidad Autonoma de Guadalajara, Mexico 1974. Available July 1981. John L. Driscoll, M.D., 631 Avenue E, Bayonne, N.J. 07002.

GASTROENTEROLOGIST/INTERNIST—31, ABIM certified, university-trained in all procedures. Seeks partnership, group practice. Also general internal medicine. Available July 1981. Write Box No. 223, c/o JOURNAL, MSNJ.

INTERNIST—Board Eligible, with some pediatric training seeks employment 20-24 hours per week preferably in 75 mile radius of Camden. Office, hospital, emergency, all okay. Rural, suburban, city, all okay. Contact secretary at (201) 431-9044 or write G. Hermann, M.D., 127 First Street, Dunellen, N.J. 08812.

PULMONARY INTERNIST, ABIM, University trained all phases Pulmonary Medicine seeks practice opportunity, available. July 1981. Write Box No. 209, c/o Journal, MSNJ.

UROLOGIST—Seeks partnership or group. American graduate, 30 years old, board eligible. Excellent training at large NYC medical center. Available July 1981. Call (212) 876-5175.

OFFICE SPACE—For Rent, Medical office space, new and fully equipped, part/full time, Ocean Medical Park, Bricktown, N.J. (201) 295-9003.

OFFICE SPACE TO SHARE—with semi-retired G.P. Ideal location in Erdman Medical building. About half-mile from exit 9, N.J. Turnpike on Route 18, East Brunswick population 35,000. Four hospitals all 10-25 minutes away. Full or part-time. Call (201) 545-4339.

OFFICE SPACE—Elizabeth. Medical office, available immediately, 1150 square feet, fully equipped and beautifully furnished. X-ray, central air conditioning, parking lot, excellent location. Call (201) 643-4444 weekdays 9-5.

OFFICE SPACE—1,300 square feet, can be divided. Growing suburban area, universities, office parks, three teaching hospitals. Ten other health professionals, including x-ray and lab in building. Madison Medical Center, 28 Walnut Street, Madison, N.J. 07940.

OFFICE SPACE—Montclair: 1200 feet, large waiting room, business office, three examining rooms. Commercial district, two blocks from Mountainside Hospital. Adequate parking. Call (201) 744-4941.

OFFICE SPACE—For Rent, unequipped physician's office at 33 West Main Street, Penns Grove, New Jersey 08069. Has been occupied by a physician for the past 29 years. Write Dr. Siris, 31 West Main Street, Penns Grove, N.J. 08069 or call (609) 299-1096 or (609) 299-2310.

OFFICE SPACE—For Rent, available on part-time basis. Fully equipped, excellent central location, superb parking, available evenings and Saturdays. Contact Box No. 575, Springfield, New Jersey 07081.

OFFICE SPACE—Woodbridge, Prestigious office suites available. 73 Main Street. (201) 548-3670.


INFORMATION FOR MEMBERS—RATES—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT**: Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o THE JOURNAL as six words. **COPY DEADLINE**: Fifth of preceding month.

FOR RENT

Office Space in Montville Township, New Jersey—600 plus—square feet with entrance on busy route 202. Other suites occupied by Dentist, Attorney and Real Estate Agency. Ample Parking.

201-334-8800 201-334-5431 201-227-1073

A PROFIT LOCATION



A PROFIT LOCATION

- FOR RENT . . . BURLINGTON COUNTY
- EXCELLENT FOR GROUP OR SOLO PRACTICE
- 2400 SQ. FT. BLDG. WILL DIVIDE
- ON WOODLANE RD., BORDERING MT. HOLLY
- NEAR HOSPITALS . . . CALL (609) 662-7766

A PROFIT LOCATION

WE PUT YOUR REAL ESTATE INVESTMENT DOLLARS TO WORK FOR YOU!

Your best investment may be purchasing a condominium unit for rental purposes. We can find that exact investment property—the one that best suits your individual needs—no matter where it might be in the United States.

All across the nation, we search for condominium conversions and newly-constructed condominiums especially suitable for investment purposes. We research each project, then make our recommendations to you. Because we're there at the conception of the conversion or construction, you buy the properties at the original and lowest prices.

- We arrange for the purchase of the condominium
- We aid in obtaining your financing
- We carefully screen and find tenants for your condominium
- We arrange management of the unit for you
- **WE SEE THAT YOUR DOLLARS ARE WORKING FOR YOU!**

We handle the investment transaction from beginning to end. And as your representative, we minimize the responsibilities of ownership. You just enjoy the advantages:

- 100% ownership
- Appreciation of investment unit
- Obvious tax breaks—depreciation on rental property, interest and property tax deductions
- At sale, your profit is capital gains, not ordinary income

Write or call Skyline Associates for more information. A representative will contact you with everything you need to know about our services.

Skyline Associates, Inc.

72 Hickory Road
Ringwood, New Jersey 07456
201/962-6300

Please contact me with additional information about condominium investments and the services you provide.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

MORRIS COUNTY, NJ

THE NEW ADDRESS FOR HEALTHY PRACTICES!

• Prime Suburban Location/Randolph Twp. Corner 200 yds off Route 10 • January 1, 1981 Occupancy • \$10 per sq ft/1st Sect • Private 1-story buildings • Suites w/indv. entrances/exits • Indiv. Lavatories/Custom installations • A/C & Carpeting supplied • Opp. Shopping Center, 2 banks, 1800 apts., high density residential area. 2 mi. to Dover General. 15 min. to Morristown Memorial & St. Clare's • Ample Parking • 1200 sq ft & up for Medical, Dental & other professionals



PROFESSIONAL ARTS PLAZA IN RANDOLPH

LEASE INFORMATION:

ON SITE: (201) 366-6384
DAYS: (201) 366-5850
EVES & WEEKENDS: (201) 239-6447

New Jersey

Pasteur

Joseph H. Kler, M.D.

Transluminal Angioplasty in
Arterial Occlusive Disease

S. R. Rodriguez, M.D.

W. H. Hardesty, M.D.

Transluminal Angioplasty of
Peripheral Vessels

J. Cholankeril, M.D., et al.

New Gastroplasty for Reflux
Esophagitis

N. J. Demos, M.D.

Complete Table of
Contents on page 80

REPUBLICQUE GABONAISE

LOUIS PASTEUR
1822-1895

POSTES

80F

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

***Check this list
against your
coverages***

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$5000 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____



Fair Oaks: A Private Psychiatric Hospital

Services provided by Fair Oaks Hospital are organized through six separate and self-contained specialty units. Each of the programs is directed by a senior psychiatrist who is a full time inpatient specialist. The psychiatrist coordinates the efforts of a staff selected for training and experience specific to the task of the unit.

NEUROPSYCHIATRIC EVALUATION PROGRAM

This program is designed to provide, within one to two weeks, a comprehensive neuropsychiatric assessment that results in specific and individualized treatment recommendations for the patient. Neurochemical, psychodiagnostic and neurological testing is combined with a family and psychosocial assessment as well as extensive clinical diagnostic interviewing based on the most modern methods of classifying psychiatric disorder. The results of this evaluation, including treatment recommendations, are provided to the referring clinician and, if the patient remains in the hospital for further treatment, to the Fair Oaks Hospital Treatment Program.

DEPRESSION EVALUATION PROGRAM

This program is designed for the comprehensive evaluation of depression and affective disorder. Headed by an authority in this area of medicine, the program utilizes the neuropsychiatric evaluation format with a special emphasis on new and reliable diagnostic biological indices of depression, such as dexamethasone suppression testing. Fair Oaks is the only specialty hospital in New Jersey to offer this innovative and comprehensive program of interview and neurobiological testing procedures.

ADOLESCENT TREATMENT PROGRAM

Fair Oaks Hospital offers a specialized evaluation and treatment program for adolescents. This program has been granted approval as an adolescent treatment program by the Joint Commission on Accreditation of Hospitals. Along with child psychiatrists, psychologists, social workers, nursing staff and recreational and creative therapists, all specially trained to work with adolescents, the program includes a formal educational experience, so that adolescents may continue their studies during treatment.

ALCOHOL AND SEDATIVE DEPENDENCE TREATMENT PROGRAM

The One Day At A Time unit offers treatment to persons dependent on alcohol or sedatives by means of a twenty-eight day program of physical stabilization, counseling and introduction to continuing supports such as Alcoholics Anonymous.

ADULT TREATMENT PROGRAM

The adult program is designed to build upon the evaluation and recommendations generated by the Neuropsychiatric Evaluation Program. Treatment of patients is continued with careful observation and monitoring of patient progress, including newly developed laboratory techniques for therapeutic drug monitoring. Interpersonal and psychosocial problems are explored and treated through group, family and individual psychotherapy. Families are seen individually and in groups in order to deal with family issues and in order to help the family keep abreast of patient progress. Furthermore, trained therapists coordinate an active program of recreational, vocational and creative therapies.

DRUG ABUSE TREATMENT PROGRAM

Utilizing new treatments developed by our physician researchers at Yale and Fair Oaks, patients are offered a treatment program that detoxifies and rehabilitates poly-drug abusers and opiate and methadone addicts. This program has developed and implemented new nonopiate treatments for addicts that make drug and opiate-free living a reality for motivated patients. Employing special tests for the biological monitoring of patient progress, specially trained staff provides treatment and works closely with family and referral source to prevent relapse.

For further information, write or call the Admissions Coordinator

Fair Oaks HOSPITAL

19 Prospect Street
Summit, New Jersey 07901
(201) 277-2300

Call Toll-Free 24 Hours a Day
In New Jersey Outside New Jersey
(800) 672-1907 (800) 526-4494

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



Officers and Trustees

PRESIDENT

Augustus L. Baker, Jr., M.D. (Morris) Dover

PRESIDENT-ELECT

Armando F. Goracci, M.D. (Gloucester) Woodbury

FIRST VICE-PRESIDENT

Howard D. Slobodian, M.D. (Middlesex) Perth Amboy

SECOND VICE-PRESIDENT

Alexander D. Kovacs, M.D. (Union) Scotch Plains

IMMEDIATE PAST-PRESIDENT

Alfred A. Alessi, M.D. (Bergen) Hackensack

SECRETARY

Arthur Bernstein, M.D. (Essex) East Orange

TREASURER

Rudolph C. Gering, M.D. (Mercer) Pennington

Trustees

CHAIRMAN

William Greifinger, M.D. (1981) (Essex) Belleville

Meyer L. Abrams, M.D. (1982) (Burlington) Cherry Hill

Frank Campo, M.D. (1981) (Mercer) Trenton

Douglas M. Costabile, M.D. (1981) (Union) Murray Hill

John J. Crosby, Jr., M.D. (1981) (Hudson) Jersey City

Anthony P. DeSpirito, M.D. (1982) (Monmouth) Neptune City

Ralph J. Fioretti, M.D. (1983) (Bergen) Rochelle Park

Palma E. Formica, M.D. (1981) (Middlesex) Old Bridge

Sherman Garrison, M.D. (1983) (Cumberland) Bridgeton

John P. Kengeter, M.D. (1981) (Ocean) Toms River

Richard E. Lang, M.D. (1981) (Passaic) Passaic

Myles C. Morrison, Jr., M.D. (1982) (Morris) Morristown

John A. Surmonte, M.D. (1981) (Salem) Penns Grove

Frank Y. Watson, M.D. (1983) (Essex) Montclair

Councilors

FIRST DISTRICT

(Essex, Morris, Union, and Warren Counties)

Merton L. Griswold, Jr., M.D. (1981) Plainfield

SECOND DISTRICT

(Bergen, Hudson, Passaic, and Sussex Counties)

Robert A. Weinstein, M.D. (1983) Newton

THIRD DISTRICT

(Hunterdon, Mercer, Middlesex, and Somerset Counties)

Albert F. Moriconi, M.D. (1982) Trenton

FOURTH DISTRICT

(Burlington, Camden, Monmouth, and Ocean Counties)

Frederick W. Durham, M.D. (1981) Haddonfield

FIFTH DISTRICT

(Atlantic, Cape May, Cumberland, Gloucester, and

Salem Counties)

Ronald M. Fisher, M.D. (1983) Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982) Hackensack

William J. D'Elia, M.D. (1981) Spring Lake

Frederick W. Durham (1982) Haddonfield

Karl T. Franzoni, M.D. (1982) Trenton

John S. Madara, M.D. (1982) Salem

Henry J. Mineur, M.D. (1982) Cranford

February 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*

Julio C. del Castillo, M.D.

John F. Marshall, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.

Harold Arlen, M.D.

Alfonse Cinotti, M.D.

Stuart D. Cook, M.D.

Robert Dodelson, M.D.

Wm. A. Dwyer, Jr., M.D.

Norman H. Ertel, M.D.

A. Olusegun Fayemi, M.D.

Arthur Goldfarb, M.D.

Robert A. Goldstone, M.D.

Murray Kahn, M.D.

Monroe S. Karetzky, M.D.

Avrum L. Katcher, M.D.

Sidney Ketyer, M.D.

Bernard J. Koven, M.D.

Joel D. Levinson, M.D.

Henry R. Liss, M.D.

Robert A. MacMillan, M.D.

Geobel A. Marin, M.D.

Murray Nussbaum, M.D.

Christopher M. Papa, M.D.

Victor Parsonnet, M.D.

Irwin W. Pollack, M.D.

Bernard A. Rineberg, M.D.

Edwin L. Rothfeld, M.D.

Benjamin F. Rush, Jr., M.D.

Morris H. Saffron, M.D.

Mark M. Singer, M.D.

Leon G. Smith, M.D.

Sheldon D. Solomon, M.D.

Lloyd N. Spindell, M.D.

A. Arthur Sugerman, M.D.

Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 921. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

Blue chip investment opportunity: *build your own office.*

Office buildings are a golden investment opportunity. They provide *utility, tax benefits, and long term growth potential*. Maximize these benefits: get complete service from a pro.

Design/Build Concept

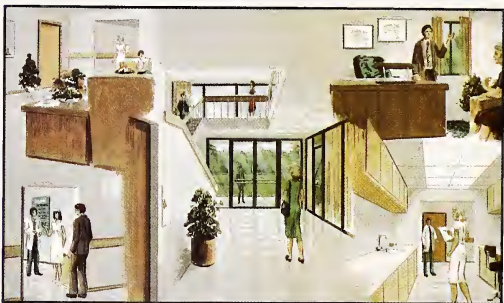
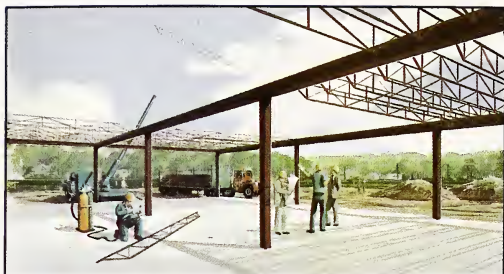
SAVE time and money. Everything needed to complete a project is in one package. Site selection, space planning, financing, management/leasing, architecture, engineering, construction, and follow-up. By centralizing responsibility DANLADI DEVELOPMENT CORPORATION minimizes the time clients must lose from their practice and maximizes time-saving construction techniques.

Space Planning

DANLADI translates *your needs* into functional and aesthetically pleasing buildings. No two practices are alike. Personalized interior layouts go hand-in-hand with customized exteriors.

Fast Tracking

Save 1/3 to 1/2 of project time. The Design/Build Concept allows DANLADI to expedite the start of work even as drawing and construction documents for later stages are under development.



Guaranteed Price

Early in the design phase DANLADI guarantees a maximum price. No cost overruns. Call us or mail this coupon today.



A Subsidiary of FLETCHER and SONS, Incorporated

To: Danladi Development Corporation

**Suite 1015, 3701 N. Broad Street
Philadelphia, PA 19140**

Telephone: (215) 223-1400

☐ Please contact me with more information on building my own office now.

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____

Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

84 **PROFESSIONAL LIABILITY COMMENTARY**

EDITORIALS

87 Grüntzig's Plaque Pressing: "Verbum Sapienti"

88 Ralph M. L. Buchanan, M.D.—1907-1980

88 GMENAC—From "Advisory to Regulatory"

91 **JEMPAC REPORTORIAL**

ORIGINAL ARTICLES

93 Transluminal Angioplasty in Treatment of Lower Extremity Arterial Occlusive Disease
S. R. Rodriguez, M.D.; W. H. Hardesty, M.D., Trenton

99 Transluminal Angioplasty of the Peripheral Vessels
J. Cholaneril, M.D.; M. Rowen, M.D.; F. Gural, R.T., Elizabeth

105 New Gastroplasty for Reflux Esophagitis
Nicholas J. Demos, M.D., Jersey City

CASE REPORTS

113 Treatment of Hypercalcemia Due to Hyperparathyroidism in Pregnancy
H. A. Levy, M.D.; L. Pierucci, M.D.; P. Stroup, M.D., Camden

116 Solitary Rectal Ulcer: Two Examples
B. D. Lifschultz, M.D.; F. A. Carone, M.D.; R. Vrla, M.D., Chicago

119 Rhabdomyolysis with Acute Renal Failure in Legionnaire's Disease
G. Gartenberg, M.D.; M. P. Weinstein, M.D.; N. K. Fernando, M.D.; R. Dodelson, M.D., New Brunswick; S. Ribot, M.D., Newark

121 **MEDICAL HISTORY**

Pasteur

Joseph H. Kler, M.D., New Brunswick

THE ELECTROCARDIOGRAM

125 Retrograde Ventriculo-Atrial Conduction in Complete Antegrade Atrioventricular Block

Shashi K. Agarwal, M.D., Albuquerque, NM

127 **ANNUAL MEETING HOUSING APPLICATION**

128 **NUTRITION UPDATE**

131 **PEDIATRIC BRIEFS**

DOCTORS' NOTEBOOK

136 Report from the Foundation

136 CMDNJ Notes

137 Physicians Seeking Location in New Jersey

140 NCI Clinical Center Study

140 ACCP Fellows

141 **LETTERS TO THE JOURNAL**

142 **LETTERS FOR THE INFORMATION OF OUR READERS**

143 **HELP FOR IMPAIRED PHYSICIANS**

145 **CME CALENDAR**

151 **OBITUARIES**

152 **BOOK REVIEWS**

Cover

The stamp for use on the cover was provided by Joseph H. Kler, M.D., of New Brunswick, ophthalmologist, medical historian and philatelist, who is the author of the article on Pasteur, page 121, this issue.



Rehabilitation is a Team Effort

New Jersey Rehabilitation Hospital, located by Exit 145 of the Garden State Parkway, is a specialty hospital which treats catastrophic injuries to spinal cord and brain, stroke, quadriplegic, paraplegia, loss of limb, musculo-skeletal injuries, neck and low back injuries, and other mental and physical impairments, often resulting from automobile or work accidents.

The goal of rehabilitation is to return disabled patients to an optimum productive life, and this involves a total team effort on the part of rehabilitation doctors, nurses, therapists, the family physician, and other specialists in the rehabilitation process. Thanks to this total team effort, NJR's patients are succeeding despite their handicaps.

To arrange for an escorted tour of our facilities, call Bucky Harris, at (201) 673-1860. We believe you'll be impressed with modern rehabilitation medicine.



New Jersey Rehabilitation Hospital

Owned and operated by Modencore Centers of America, Inc.

240 Central Avenue, East Orange, NJ 07018 • 201-673-1860

Bertrand J. Bensam, MD, Medical Director • Stanley Shepard, Administrator

Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities and the American Board for Certification in Orthotics and Prosthetics Inc.

Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white glossy

prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.

SPECIFY
ZYLOPRIM[®]
(allopurinol)
THE
ORIGINAL
ALLOPURINOL



Two convenient dosage forms:
100 mg (white) and 300 mg (peach)
Scored Tablets



Tablets imprinted with brand name to
assist in tablet identification.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Professional Liability Commentary

Featuring: 1980's Malpractice Hit List

"Plaintiffs' attorneys today see a public that's more demanding and more willing to sue as a result of all the publicity in recent years about impaired physicians, botched surgery, unnecessary procedures, and the high cost of treatment. There are now many more attorneys specializing in malpractice cases, and they're more knowledgeable about medical matters," so states Mark Holoweiko, author of an article entitled "Here's the Malpractice Hit List for the '80's," in the November 24, 1980 issue of *Medical Economics*.

A number of prominent malpractice attorneys were interviewed to determine the types of malpractice occurrence attorneys will be concentrating on during the '80's. The following list is a composite of the attorneys "hit list."

Physicians' Reluctance to Refer—New York Attorney Alfred S. Julien puts it this way, "Rather than jeopardize their egos by referring patients to more knowledgeable colleagues, medical specialists are treating patients outside their disciplines."

Communication Foulups Among Physicians—San Francisco Attorney Arne Werchick states, "Doctors treating a particular hospitalized patient used to sit down together and discuss treatment. Now they're too busy. So instead of conducting a clinical conference, they rely on the chart, the telephone, and the mail."

Drug-Related Birth Defects—Los Angeles Attorney James G. Butler optimized, "... soon—perhaps within the next six months—I'm sure that research will show a positive link between human birth defects and drugs taken during pregnancy."

Widespread Carelessness in Obstetrics—Harvey F. Wachsman, a neurosurgeon who became a plaintiffs' attorney states, "I've found that detailed notes on doctors' OB charts are virtually non-existent. Obstetricians frequently neglect to monitor for signs of fetal distress during delivery, injudiciously use drugs to accelerate the onset of labor, and fail to evaluate the size of the midpelvis so that preparations for a cesarean section can be made before a baby gets hung up in the birth canal."

Misguided Efforts to Cut Cost—"Attorney Irwin Birnbaum of Syracuse, N.Y., contends that many doctors are shooting from the hip in treating patients, rather than ordering tests that could confirm their educated guesses about appropriate therapy."

Proliferation of Psychiatric Standards—"A patient's suicide can itself be flagrant evidence of negligence," Chicago Attorney Susan E. Loggans asserts. "Once people are committed to an institution, they're cut off from their families and left utterly dependent on the doctor and hospital. It's similar to how children totally rely on their parents for safety. So I'd say that if a physician has any knowledge of a patient's self-destructive tendencies, then he or she in effect becomes the insurer of the patient's life."

Legitimization of "Wrongful Birth" Suits—"Social mores haven't changed so rapidly that it's become easy to convince a court to award damages for the birth of a normal, healthy baby," says Washington, D.C., lawyer Richard T. Tomar. "But that will likely be one of the major developments of the '80's. Patients should be compensated for the tremendous emotional and economic harm inflicted upon them through negligently performed vasectomies, tubal ligations, and abortions."

DID YOU KNOW

... The Medical Inter-Insurance Exchange of New Jersey will be requesting the New Jersey State Department of Insurance to grant a 9.7 percent increase.

... Four states which lead in awarding million dollar jury verdicts are California (59), Florida (46), New York (42), and Michigan (32). The largest awards have been in the area of product liability." *Malpractice Lifeline*, November 28, 1980.

... "\$4.6 million with potential payout value of \$26 million, the largest malpractice settlement in California and probably in the country, recently was awarded to a 6-year-old spastic athetoid quadriparetic. Plaintiff contended that an unreasonable delay in performing an emergency cesarean section caused the injury." *Personal Injury Newsletter*, September 1980.

ANOTHER VOICE

The following excerpts appeared in an editorial, entitled, "Counsel Fees Again," in the November 6, 1980 issue of the *New Jersey Law Journal*:

"Recurrently since 1948 our courts, commentators and various committees have wrestled with the 'American rule,' under which the prevailing litigant ordinarily is not entitled to collect a reasonable attorney's fee from the loser.

"We think the time has come to reconsider once again whether to permit such awards, at least under egregious circumstances where the losing party has conducted the litigation with clearly demonstrable bad faith.

"The ill-founded, specious lawsuit is one of the causes for the accelerating press of litigation and the consequential burden upon our courts. Professional groups challenging the multiplicity of professional malpractice suits, and insurance companies urging employment of the verbal threshold test in our no-fault insurance law are able to trot out a war chest of favorite stories illustrating the costly impact of suits instituted solely for the purpose of producing nuisance settlements.

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

"A rule that, at least, permits counsel fee allowances where the losing litigant has acted wantonly, recklessly or without good cause would curb such frivolous litigation. We recognize that at the outset this might spawn a rash of collateral proceedings to determine the propriety of the litigant's action and the amount of fees to be awarded, but these would be limited in scope. Perhaps a threshold ruling by the court, awarding final judgment that a prima facie case exists for the imposition of such fees, would suffice to limit such post-judgment proceedings.

"What we urge, in short, is that parties pay for the privilege of frivolously employing the judicial process to advance their bargaining or economic positions, at least to the extent of compensating the other side for the cost of resisting such tactics. Every change, of course, creates uncertainty. There obviously is no clear-cut methodology to eliminate the frivolous lawsuit or spurious discovery tactic. But the litigant who knowingly and deliberately employs the judicial process solely to achieve a bargaining ploy to which he would not otherwise be entitled on the merits should pay the price."

PHYSICIAN ALERT: ALL PHYSICIANS EMPLOYED BY THE STATE OF NEW JERSEY

Under the Tort Claims Act, Chapter 10, Section 59:10-1, the Attorney General provides for the defense of an employee or former employee and shall provide indemnification for the State employee.

Section 59:10-3 is concerned with the employee's duty to notify and cooperate with the Attorney General and is of crucial importance to those physicians employed by the State

of New Jersey.

"A State employee **shall not** be entitled to indemnification under this act unless within **10 calendar days** of the time he is served with any summons, complaint, process, notice, demand or pleading, he delivers the original or a copy thereof to the Attorney General or his designee. Upon such delivery the Attorney General *may*, pursuant to the provisions of Senate Bill No. 993, now pending before the legislature, assume exclusive control of the employee's representation and such employee shall cooperate fully with the Attorney General's defense."

CONFERRING WITH PLAINTIFF ATTORNEY

American Medical News, in its November 28, 1980 issue, offers advice to physicians regarding the avoidance of the frivolous malpractice suit. The article offers two view-points, one is that of plaintiff attorney, Michael Volk, and the other is that of defense attorney, Henry B. Alsobrook.

Those individuals connected with this Department and those of the medical insurance industry heartily concur with defense attorney Alsobrook's advice and *not* with plaintiff attorney Volk.

In particular, physicians should be mindful that plaintiff attorneys involved in professional liability claims are "playing to win." If an attorney representing a patient requests a conference with a physician to discuss a patient's allegations the physician immediately should contact his insurance carrier. Only after the physician has been fully advised of the law and the case has been reviewed by a defense attorney should the decision be made to meet with the plaintiff's attorney.

The Medical Society of New Jersey PRESENTS MEDICAL MALPRACTICE SEMINARS FOR AS LITTLE AS \$45.00

**Professional Liability and the Obstetrician/Gynecologist
Professional Liability and the Orthopedic Surgeon
Professional Liability and the Anesthesiologist
Professional Liability and the General Surgeon
Professional Liability and Internal Medicine**

The Department of Professional Liability Control of the Medical Society of New Jersey has developed *professional liability video tapes aimed at specific medical specialties*. The 3/4 inch video tapes incorporate a "talk show" format featuring James E. George, a physician-attorney, and two physicians representing the medical specialty subject of the tape. Each of the 45-55 minute 3/4 inch video tapes is designed to encourage post-viewing discussion and is available for a \$45.00 rental fee.

TOPICS INCLUDE

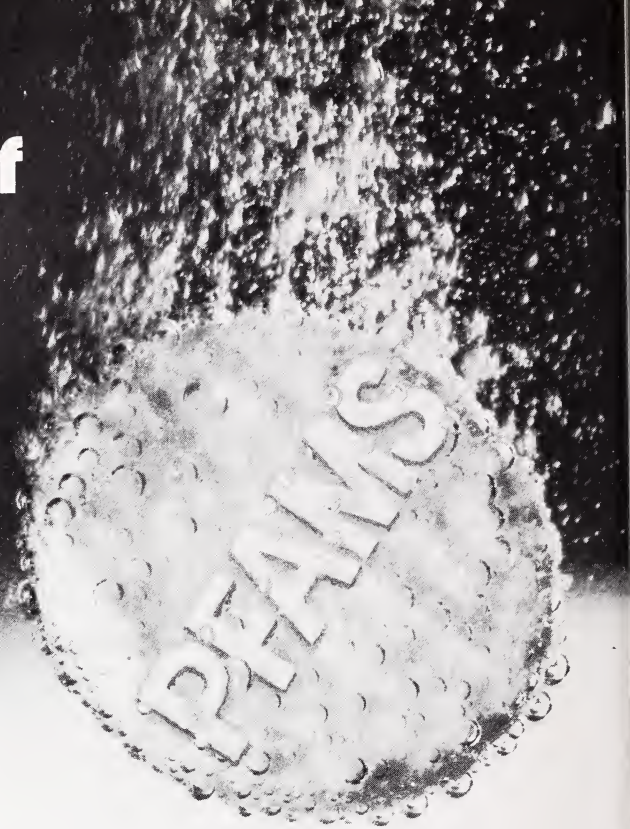
- General assessments of professional liability
- Informed consent
- Multiple-physician consultants
- Medical Records
- Physician to physician and physician to staff communications
- Group practice
- Emergency Room programs
- Three "R's" of malpractice prevention

Category I AMA accreditation can be obtained if the video tapes are used as part of a planned program in conjunction with a moderator.

For more information please contact the Department of Professional Liability Control at the Medical Society of New Jersey (609) 896-1766.

All tapes carry the copyright of MSNJ and may not be reproduced or distributed in any form or fashion without the express written consent of the Medical Society of New Jersey.
Copyright 1980

For the Fastest Relief Known to the Medical Profession



Take the most advanced medical management system in the industry: PFAMS, our Patient Financial Accounting Management System. Once you do, we guarantee relief.

Complete relief. From accounts receivable that have grown far too old. From insufficient cash flow. And from too many hours spent making too little profit.

With PFAMS, you'll get relief from all your accounting, billing, insurance processing and management headaches. And you'll get it fast.

It's the combination of ingredients that does it. You get a video display station and printer hook up to our powerful DEC system. You get complete technical training for your staff. And you get the expertise and guidance of people who know how to make it all work to your advantage.

For the progressive medical practice with 1 to 35 doctors, it's a unique and comprehensive package, formulated to keep your practice financially healthy. And best of all, it's priced to be easy to take.

So call or write today. We'll tell you how to get PFAMS into your system, which will make you feel better in no time.

niscorp

**Bernards Professional Center
150 North Finley Avenue
Basking Ridge, N.J. 07920
(201) 221-0900**

Grüntzig's Plaque Pressing: "Verbum Sapienti"*

It is timely that this issue of *The Journal* contains two articles on transluminal balloon dilatation for stenotic or occluded iliac and femoral arteries. Although the two reports are generally similar, they differ with regard to indications for treatment and patient selection, as well as conclusions and enthusiasm for the procedure. These subtle differences are clear to those familiar with the standard methods of treatment of occlusive vascular disease.

Transluminal balloon dilatation is not the categorical substitute for surgery that some exuberant supporters espouse it to be. Assessment of the procedure has been based on early experiences; the number of patients, and the length of followup are still insufficient to permit reliable or definitive conclusions. It will be a few more years before analysis of data will permit a valid comparison of the results with those of established surgical methods. Nonetheless, enough experience has been gained to provide guidelines by which practical therapeutic attitudes may be considered.

In carefully selected patients, dilatation has resulted in an 85 percent early patency rate and improved blood flow to the compromised limb. The low risk, shorter hospitalization, avoidance of general anesthesia, and presumed cost effectiveness enhance its appeal, even though complications such as hemorrhage, thrombosis, arterial dissection, embolization, and limb loss all have been reported.

The answers to certain important questions still are wanting. For example, what are the relative and absolute indications for intervention? Will the early successes prove durable? How does balloon dilatation compare with the known results of reconstructive vascular surgery? Who should do the procedure? How will peer review and quality control be accomplished?

It has been recommended that patient selection should be made in consultation with the attending physician, the angiographer, and especially with an expert in vascular diseases who understands the natural history of occlusive arterial disease and can correlate the pathologic anatomy with symptoms and physical findings. He, logically, will have the judgment to weigh the proposed treatment with other more standard means of management. The vascular surgeon is the logical expert to serve in this consultative function. This choice should not be interpreted as a form of jurisdictional divisiveness or surgical guildism. Angiographers themselves have agreed that good patient selection and optimal results are more likely when vascular surgeons are consulted.¹ Moreover, their advice and assistance surely will be needed should a critical complication occur.

This discussion is pertinent to hospital administrators and the committees that establish operative privileges. Certainly privileges should not be granted to perform transluminal

dilatation to anyone not trained in angiography and "invasive radiology." Clinical decisions regarding patient selection and mode of therapy demand the participation of the vascular surgeon.

Arteriograms of patients with mild claudication often reveal lesions that appear suitable for dilatation. But an anatomically suitable lesion per se is *not* an indication for treatment. It must be evaluated along with the patient's clinical complaints, the degree of disability, and the known progress of the disease. Moreover, a "suitable lesion" is difficult to define. Certainly extensively calcified stenoses and long areas of obstruction are not suitable. There is also much doubt that a patient with mild non-disabling claudication requires invasive treatment of any kind.

Threatened limb loss and severe disabling claudication remain the important indications for invasive intervention. Later on, perhaps, a more lenient attitude will be adopted for treating patients with mild intermittent claudication by balloon dilatation. As it is, the natural course of the disease in such individuals is so benign with regard to limb survival that it is doubtful that the prognosis will be enhanced by any form of treatment. On the other hand, more aggressive vascular surgeons who favor revascularization report a 75 to 80 percent graft patency rate at five years and "only" a three percent limb loss. In fact, balloon dilatation probably could be supported if similar long-term results were duplicated. For now, we should restrict the indications for balloon dilatation to patients with impending limb loss or severe disabling claudication.

Claims have been made for the cost effectiveness of balloon dilatation. However, as yet we do not know the length of stay required for patient assessment, the time of occurrence and frequency of complications, the frequency of retreatment, or even what equitable fees should be. We are not sure that dilatation will be anything more than the first step in a variety of subsequent vascular reconstructions.

It is premature to consider transluminal balloon dilatation competitive with vascular surgery or as an alternative to it. Its role will be crystallized only when documented data are available on its effectiveness and durability. Until such time, the procedure should be regarded as an adjunct to the surgical therapeutic armamentarium, and one which should still be considered investigative.

J. Alpert, M.D.

*The principal author of the editorial is Joseph Alpert, M.D., Director of Peripheral Vascular Surgery, Newark Beth Israel Medical Center, Newark. Contributing authors, members of the Vascular Surgical Service, are V. Parsonnet, M.D., D.K. Brief, M.D., B.J. Brenner, M.D., and R.J. Goldenkranz, M.D.

¹Dotter, C.T., Rosch, J., Judkins, M.P.: Transluminal dilatation of atherosclerotic stenosis. *Surg Gynecol Obstet* 127:794-804, 1968.

Ralph M. L. Buchanan, M.D.—1907-1980

Ralph McKay LaShelle Buchanan, 169th President of the Medical Society of New Jersey, died on November 20, 1980. Dr. Buchanan, who was born in St. Clair, Pennsylvania on November 23, 1907 of Scottish and Welsh parents, was the seventh son of John and Margaret Buchanan.

Educated in the public schools of St. Clair, the Pottsville High School, Mercersburg (Pennsylvania) Academy (where he was awarded an athletic scholarship for track) and Lafayette College, Ralph Buchanan studied medicine at Hahnemann Medical College and was graduated in the class of 1933. His medical education included an internship at the West Chester (Pennsylvania) Homeopathic Hospital and residency training at the Abington (Pennsylvania) Memorial Hospital and the Warren Hospital in Phillipsburg, New Jersey.

Dr. Buchanan's affiliation with MSNJ began in 1936. He was secretary of the Warren County Medical Society for 30 years and was the only member to serve two consecutive terms as its president. He was President of MSNJ in

1961-1962 and served on the State Board of Medical Examiners of New Jersey for 17 years, during seven of which he was the President of the Board. He also was the President of the Industrial Medical Society of New Jersey, a senior member of the Society of Surgeons of New Jersey and a Fellow of the Academy of Medicine of New Jersey.

Dr. Buchanan's fellowships also included the American College of Surgeons, the International College of Surgeons, the Industrial Medicine Association and the British Royal Society of Health. He was awarded a "Citation for Meritorious Service" by the President's Committee on Employment of the Physically Handicapped in 1967.

Dr. Buchanan served his patients, his community and organized medicine well. Although his roots began in Pennsylvania, the State of New Jersey was most fortunate that he was transplanted here where he made a major impact on New Jersey medicine through his tireless efforts.

Ralph and Grace Albinson Buchanan had two sons and two daughters and nine grandchildren. A.K.

GMENAC—From "Advisory to Regulatory" Another Bureaucracy to Contend With

The Graduate Medical Education National Advisory Committee (GMENAC) chartered in 1976 by the Secretary of Health and Human Services recently completed a four-year major study of issues related to the future distribution of physicians in this country by specialty and geographic location.

In 1975, the Association of Professors of Medicine established a task power on manpower need in Internal Medicine. Dr. Alvin R. Tarlov, FACP, Chairman of the Department of Medicine of the University of Chicago's Pritzker School of Medicine, was appointed to the committee. In 1978, Secretary of Health, Education and Welfare Califano requested Dr. Tarlov to serve as Chairman of GMENAC.

The committee consisted of 19 members from the private sector and three from the government. A staff of about 25 from the Department of Health and Human Services provided data and technical expertise. In addition, 180 physicians from the private sector and 30 non-physician health care providers also participated in Delphi panels. Judgments on the norms of care, incidence and prevalence of various diseases and physician productivity were made and compared to published data.

From this rather extensive and detailed study there were 107 recommendations which had been condensed in the Summary Report to 40. Approximately 15 or so recommendations on the decrease in the country's aggregate number of physicians call for an immediate decrease in the entering classes in medical schools, a decrease in the number of the U.S. citizens studying medicine abroad and a decrease in the entry into training and practice of the aliens who have attended foreign medical schools.

GMENAC concluded in its seven volume report that in 1990 there would be substantial surpluses of physicians in

some specialties including internal medicine subspecialties and surgery and shortages in some others. Recommendations have been made to redress these imbalances in specialty training programs; in addition, specialists should do less primary care in the future. By 1986, no specialty would be expected to increase or decrease its number of residents by more than 20 percent.

The GMENAC Committee has completed its assigned task and it has recommended that GMENAC be continued for the following reasons:

- (1) To monitor the success of its projections and to be able to evaluate it.
- (2) To be able to evaluate six specialties which did not have the application of GMENAC's methodology, namely: neurology, pathology, radiology, nuclear medicine, anesthesiology and physical medicine and rehabilitation.
- (3) To do research and analysis on financial issues, to help determine whether variations in the physician's expected income play an important role in choice of specialty and location.
- (4) To solve the problem of geographic distribution of physicians.
- (5) To study the role of non-physician health care providers in the delivery of health services.

Approximately 80 percent of the direct costs of graduate medical training are met by revenues derived from patient care, almost entirely in the hospital setting, of which many are patients over age 65. Consequently, government financing of care plays a significant role.

Once GMENAC's report was formally presented to the Secretary of Health and Human Services, it sparked controversy and debate. James H. Sammons, M.D., the Executive Vice-President of the American Medical Association

(AMA) stated that "Because of the methodology used, it is necessary to view the report and the recommendations with caution before they are applied to the American health care system." He further stated, "There is a necessity for evaluation and determining the nation's health needs." He expressed "concern that this report has the potential to set the American system on a rigidly defined course with little flexibility of goals or the means of obtaining them."

"We must keep in mind that while GMENAC findings may provide interesting assessment of manpower physicians and supply today, history has shown that long-term medical manpower projections are extremely difficult to make given changing economic trends, technological innovations, a mobile population, and a rising demand for services," Dr. Sammons has reported.

Critics have objected to the GMENAC's Report as a collaboration between the private sector and the government. Others have noted that an over supply of physicians is not a problem, but a positive social benefit in providing needed services. The possibility arises that the report will be used to revamp funding mechanisms for graduate training.

The American Society of Internal Medicine (ASIM) recently has expressed concern at the Conference on Health Manpower Bills, S. 2375 and H.R. 7203. Section 712 of H.R. 7203 provides permanent statutory authority for the continuation of GMENAC and gives it a broad mandate to study and make recommendations on health manpower and related issues. Senate Bill S. 2375, does not contain a comparable provision.

ASIM feels that "there is no need to continue GMENAC by statute, since the original GMENAC Report already

addressed the major manpower issue (except for "modeling" of the few specialties). Many of the recommendations in the GMENAC Report are controversial. These recommendations require close scrutiny and resolution before embarking on another effort that is likely to lead only to a new set of recommendations, either redundant or secondary in nature. Its continuation would constitute an unnecessary expenditure of funds." Furthermore, ASIM concluded that "it is wary of advisory committees that actively seek their own continuation when their original task has been completed." The potential for GMENAC's activity to evolve from "advisory" to regulatory "exists at a time when federal government should be disengaging from its efforts to regulate the number and kinds of physicians."

In conclusion, GMENAC, an advisory committee which set out to do a task, having completed it, recommends that its committee be allowed to continue. Several bills are now being considered in Congress to allow GMENAC to continue by statute, and if these bills pass, GMENAC will be another bureaucracy to contend with by practicing physicians and medical educators.

References

¹*Forum on Medicine*. American College of Physicians, November 1980, pp 699-704.

²*The American Medical News*. October 10, 1980, pp 1-16.

³Correspondence from the American Society of Internal Medicine, dated November 12, 1980, to Congressman Henry A. Waxman, Conference on Health, Manpower Bills, S. 2375 and H.R. 7203.

Frank J. Malta, M.D.
Immediate Past President, NJSIM

An added complication... in the treatment of bacterial bronchitis*



Brief Summary Consult the package literature for prescribing information

Indications and Usage: Ceflor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceflor.

Contraindication: Ceflor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceflor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceflor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceflor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinette® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose of 4 g tid for seven times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceflor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceflor.⁷

Ceflor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic:—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic:—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal:—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceflor® (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients. Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother. 8: 91, 1975.
2. Antimicrob. Agents Chemother. 11: 470, 1977.
3. Antimicrob. Agents Chemother. 13: 584, 1978.
4. Antimicrob. Agents Chemother. 12: 480, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C. American Society for Microbiology, 1976.
6. Antimicrob. Agents Chemother. 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the professor or request from:
Eli Lilly and Company
Indianapolis, Indiana 46205
Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

100601

SPENDING TIED TO ELECTION SUCCESS

An article in the November 17, 1980 issue of the *Washington Post* cited Federal Election Commission statistics reporting seven of the ten candidates receiving the most funds from PAC committees won their election contests.

The most noteworthy were Representative Charles Gyassley (R—Iowa) who received \$504,809 in PAC contributions and defeated John Culver, Representative Steve Symms (R—Idaho) who received \$468,450 in PAC contributions and defeated Frank Church, Representative James Abdor (R—South Dakota) who received \$457,735 and defeated George McGovern, and Representative Dan Quayle (R—Indiana) who received \$438,487 and defeated Birch Bayh.

POIGNANT POLITICS

"The budget should be balanced, the treasury should be refilled, public debt should be reduced, the arrogance of officialdom should be tempered and controlled, and assistance to foreign lands should be reduced lest the State

MSNJ'S POSITION ON PROPOSED NJ LEGISLATION

Senate-251—Anthony E. Russo (20th District, part of Union)

To authorize the Division of Motor Vehicles to note on a driver's license that the licensee has diabetes. *ACTIVE OPPOSITION* because it neither advances the health interests of patients with diabetes nor would it lead to any recognizable results in highway safety. Assigned to **Institutions, Health and Welfare Committee**: Anthony Scardino, Chairman, William J. Hamilton, Vice-Chairman, Anthony E. Russo, Garrett Hagedorn, James P. Vreeland.

Senate-11—Laurence S. Weiss (19th District, part of Middlesex)

To provide that drugs manufactured by certain drug manufacturers shall be covered by product liability insurance. *CONDITIONAL APPROVAL* pending the addition of the following amendment to the bill: "c. provide products liability indemnity protection to each physician prescribing or dispensing their products." Assigned to **Labor, Industry and Professions Committee**: Eugene Bedell, Chairman, An-

1981

GUBERNATORIAL ELECTION YEAR

1981

become bankrupt. The people should be forced to work and not depend on government for subsistence." Marcus Tullius Cicero, 106 B.C.

CALL TOLL-FREE TO LEARN ABOUT LEGISLATION

The Legislative Service Agency has a Division of Research and Information which will answer all inquiries concerning the Legislature, legislative process, and legislation. New Jersey residents may make inquiries by calling (toll-free) (800) 792-8630 or writing to Room 128, State House, Trenton, New Jersey 08625.

JEMPAC CALENDAR

A desk calendar was prepared by the New Jersey Medical Political Action Committee (JEMPAC) of the Medical Society of New Jersey for 1980 members of JEMPAC, in appreciation of their membership support. A limited number of these calendars are available and will be sent to Medical Society of New Jersey members upon request to the JEMPAC office at MSNJ headquarters—(609) 896-1766.

thony Scardino, Vice-Chairman, John T. Gregorio, Brian Kennedy, James Wallwork.

We urge you to write to the sponsors, the committee and committee members to make MSNJ's views known—c/o the State House, Trenton, NJ 08625.

LETTER OF COMMENDATION

October 23, 1980

Dear Ms. O'Hare:

Congratulations! Due to our joint fund-raising efforts with JEMPAC, AMPAC has exceeded its alltime high membership record in New Jersey for 1980.

On behalf of the AMPAC Board of Directors, please accept our gratitude for this outstanding accomplishment. Once again we thank you and hope you will convey to the JEMPAC Board of Directors our appreciation for your increased efforts in our joint fund-raising activities.

(signed) Michael P. Lewis, M.D., Chairman
AMPAC Board of Trustees

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® 5^{mg.} / 10^{mg.} / 25^{mg.} Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Transluminal Angioplasty in the Treatment of Lower Extremity Arterial Occlusive Disease*

SILVIO R. RODRIGUEZ, M.D. and WILLIAM H. HARDESTY, M.D., Trenton

Our limited experience has shown transluminal angioplasty (TLA) to be useful by itself and in conjunction with other arterial surgical procedures. Presented are four cases to illustrate the type of patient who might benefit from this technique. In addition, a brief outline of the applicability and technology are discussed. We suspect TLA will play an increasingly important role as part of the vascular surgeon's armamentarium.

In 1963, Dotter and Judkins first described dilatation of atherosclerotic obstructed vessels in the lower extremities by a percutaneous method.¹ This procedure involved progressive dilatation by a series of increasingly large coaxial catheters. Unfortunately, this technique can result in complications such as puncture site problems and damage to the treated vessel during catheter advancement. A decade later, Grüntzig developed a catheter which dilated vessels by inflating a balloon near its tip.² This avoided some of the complications inherent in the so-called "Dotter technique." One advantage of both techniques is that they can be done under local anesthesia with avoidance of extensive operative procedures. We have had a limited experience using the transluminal angioplasty (TLA) catheter of Grüntzig; however, we feel it will play an increasing role in the treatment of arterial occlusive disease.

TECHNIQUE

The catheter (Figure 1) is a double lumen device which allows dye injections or pressure measurements through one lumen and balloon dilatation through the other lumen. The balloon, which can be filled with contrast material so that its inflation can be observed fluoroscopically, is made of polyvinyl chloride and allows a relatively uniform fixed diameter to be maintained as the balloon is inflated against resistance. The catheter is placed using local anesthesia by the Seldinger technique.³ It is passed over a "J" tip wire

which previously has been passed through the obstructed or narrowed area. Expansion of the balloon requires 3.5 to 6 atmospheres of pressure to its maximum diameter over a 30 to 60 second period. Several dilatations may be necessary in one location because of the length of the involved vessel in relation to the balloon length. Thus it may be necessary to advance or retract the catheter, inflating the balloon periodically.

Intravenous or intra-arterial heparin (5,000 units) is injected just before passage of the guide wire and repeated every six hours for 24 hours. Thereafter either aspirin or dipyridamole (Persantine®) alone or in combination are administered on a long-term basis. Grüntzig recommends long-term anticoagulation with warfarin sodium (Coumadin®) unless contraindicated. He also uses sulfipyrazone (Anturane®) 200 mg. q.i.d. for four days before TLA for platelet inhibition.

CLINICAL INDICATIONS FOR TLA

The clinical indications for TLA are the same as for any other arterial procedure in the lower extremity. The patients

*Presented at the scientific meeting of the Vascular Society of New Jersey, Christ Hospital, Jersey City, New Jersey, March 12, 1980. Dr. Rodriguez is senior surgical resident, Graduate Hospital of the University of Pennsylvania. Dr. Hardesty is Assistant Clinical Professor, Department of Surgery, Graduate Hospital of the University of Pennsylvania and Chief of Vascular Surgery, Mercer Medical Center, Trenton. Correspondence may be addressed to Dr. Hardesty at 416 Bellevue Ave., Trenton 08618.

“... only stenotic but not completely occluded lesions of the iliac system are suitable for TLA ...”

“Complications ... include ... hemorrhage at the puncture side ... distal embolization ... subintimal dissection of the atheromatous area.”

are told beforehand that if the technique is unsuccessful or if there are any complications arising from the procedure, surgery may be required soon after. Indications include limiting claudication, ischemic rest pain and failure of an ischemic ulcer to heal with nonoperative therapy. The indications may be expanded as experience is gained and it can be shown that complications are infrequent.

From an angiographic point of view only stenotic but not completely occluded lesions of the iliac system are suitable for TLA, because of the tortuosity of the iliac arteries when occluded and the associated risk of perforation and hemorrhage in an area which is difficult to control. A single stenotic area or multiple short iliac artery stenoses of two cm or less located at the origin of the common or external iliac artery are ideal. In the femoral and popliteal vessels, only occlusions less than 10cm in length are treated because of the poor results reported in patients in whom the segments are longer.⁴ Another indication for TLA is dilatation of previously inserted vein grafts which have become stenotic.⁵ This is obviously simpler and less complicated than exposing the graft for repair.

COMPLICATIONS

Complications of transluminal angioplasty include hemorrhage at the puncture site which occurs in about two percent of cases.^{6,7} Grüntzig reported distal embolization in five percent of 303 cases; most of these were demonstrated angiographically, but were not clinically significant.⁴ Subintimal dissection of the atheromatous area followed by thromboses of the vessel and/or distal embolization also have been reported.⁴ Followup studies after the “Dotter” or the “Grüntzig” technique have shown twice the reocclusion rates for femoral and popliteal lesions if long-term anticoagulation is not used.^{8,9}

CLINICAL EXPERIENCE

Although percutaneous transluminal dilatation has been available for more than a decade, experience with this procedure has been limited in America. Consequently, significant figures for long-term followup are not available. Grüntzig has reported a two-year patency rate of 72 percent for superficial femoral artery disease and 87 percent for iliac artery stenoses.⁴ A more recent study reported an initial success rate of 89 percent in the femoral and 94 percent in the iliac artery.⁸ Because the procedure can be repeated with relative ease, it is possible to redilate with very low risk to the patient if stenosis reoccurs.

Four patients in whom we have measured segmental limb pressures (Doppler method) in the lower extremities before and after dilatation are reported (see table 1). In one of these patients pre and postdilatation intra-arterial pressures also were measured.

Ankle-Brachial indexes (A/B index) obtained by dividing the ankle pressure by the arm blood pressure were measured in all four patients before and after dilatation as an indication of the degree of functional arterial obstruction and the improvement of blood flow after TLA.

We have performed the procedure in the angiography room of the x-ray department and in the operating room in conjunction with more distal or proximal vascular repairs. The balloon diameter and length have varied, depending on the location of the stenotic area.

CASE 1

A 62-year-old hypertensive, obese male previously had a right femoral-popliteal bypass for claudication. He complained of intermittent claudication in the left lower extremity which he felt was disabling. An arteriogram demonstrated stenosis of the left common iliac near its origin. (Figure 2). TLA was performed through the same arteriographic puncture site. Postoperatively, the symptoms disappeared. Non-invasive laboratory assessment was performed pre and postdilatation and the results are reported in Table I. Three months later, a repeat distal aortogram revealed the dilated segment to be patent (Figure 3).

CASE 2

A 67-year-old male was suffering with angina and also complained of bluish discoloration of the left great toe. In July 1979, a femoral-femoral crossover vein graft, left common femoral artery endarterectomy and venous patch graft were performed. In the operating room, the left superficial femoral artery stenosis was dilated under fluoroscopic control by passing the Grüntzig catheter through the opened common femoral artery.

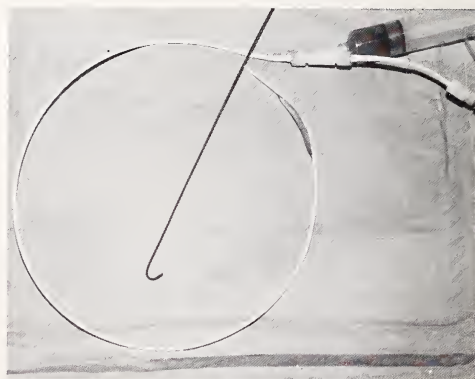


Figure 1—Dilating Balloon catheter and “J” guide wire.

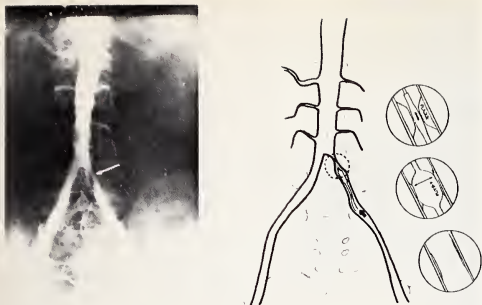


Figure 2—Left: Arteriogram shows stenosis of the left common iliac artery (arrow).

Eight weeks later, when his symptoms had returned, laboratory studies showed a reduction in his left lower extremity pressures. A repeat arteriogram demonstrated stenosis of the femoral-femoral vein graft and a restenosis of the left superficial femoral vessel near Hunter's abductor canal. At surgery the crossover graft was found to be clotted. After performing a thrombectomy of the graft, TLA was utilized to dilate the vein graft and the superficial femoral artery stenoses. Postoperatively the left lower extremity pressure improved dramatically and the toe discoloration disappeared. Three months following this last procedure the left popliteal pulse was not palpable; there was reduction of his left ankle and transmetatarsal pressures, but his thigh pressure and left femoral pulse remained as before (table 1). In all probability the superficial femoral artery had restenosed or occluded, but the crossover vein graft remained patent. Although his vascular laboratory results were relatively unchanged, since the clinical improvements remained, no further treatment has been necessary.

CASE 3

A 41-year-old female had a history of claudication in the right calf and nocturnal pain in the right lower extremity. Her vascular laboratory evaluation is presented in table 1. An arteriogram showed stenosis of the right iliac artery, right superficial femoral artery and right popliteal artery. A TLA of the right iliac artery was done at the same time as the arteriogram. The following day, a right popliteal artery endarterectomy and vein patch angioplasty were done. A catheter was passed proximally through the opened popliteal artery to dilate the superficial femoral artery at its origin. Postoperatively, the patient developed a strong right popliteal and right dorsalis pedis pulse and experienced dramatic improvement of her symptoms.

CASE 4

A 55-year-old diabetic male had intermittent claudication in both hips and lower extremities which interfered with his occupation. Arteriography showed bilateral external iliac artery stenosis. Intra-arterial pressures were measured above and below the left iliac stenosis. The systolic pressure was 134 and 114 mm of Hg respectively. A Grüntzig catheter was then introduced and dilatation was accomplished. Pressures were remeasured above and below and found to be 137 and



Figure 3—Three months after TLA, arteriogram in case 1 shows segment remains patent.

Table 1
Vascular Laboratory Results
(Segmental Doppler Pressures mm/Hg)

	Thigh	Calf	Ankle	A/B Indexes
Case 1				
Left lower extremity				
Before TLA	80	74	52	0.2
After 1 day	134	120	102	0.7
After 3 weeks	148	132	114	0.6
Case 2				
Left lower extremity				
Before TLA	60	48	52	0.4
After 2 weeks	70	86	90	0.6
After 12 weeks	70	82	68	0.5
Case 3				
Right lower extremity				
Before TLA	116	66	30	0.1
After 1 week	*104	122	124	0.8
After 6 weeks	160	146	148	0.8
Case 4				
Left lower extremity				
Before TLA	102	114	100	0.6
After 9 weeks	110	108	100	0.6

* Exact pressure was not measured because of pain in incision area.

135mm of Hg respectively. An attempt was made to do a similar procedure on the right side, but failed because of technical difficulties; the catheter was withdrawn and the procedure postponed. Although his lower extremity segmental pressures did not change, the patient experienced notable improvement in his left lower extremity claudication symptoms (table).

SUMMARY

Since Dotter and Judkins first introduced percutaneous angioplasty in 1963 their technique has evolved in its use and applications. The "Dotter" technique of transluminal dilatation has been used in only a few institutions in this country, but an extensive clinical experience has been gained internationally.

In 1973, Grüntzig developed a balloon catheter and perfected a new transluminal dilatation technique. These catheters are now available in a variety of diameters and lengths for each specific use. Since then, numerous reports have described its use and success in the treatment of occlusive vascular disease.

Although the long-term results of TLA may be limited, the low risk, low morbidity, low cost and initial success rate reported by several authors make this technique very attractive and useful.

Recently, we have used TLA for the treatment of iliac artery, femoral artery and vein graft stenoses, either percutaneously or in the operating room in conjunction with other vascular procedures, with good results.

Four illustrative cases are presented which describe the indications, technique, and applications in the management of lower extremity ischemic disease with TLA. We strongly believe this technique of transluminal angioplasty has a role in the vascular surgeon's armamentarium.

REFERENCES

1. Dotter CT, Judkins MP: Transluminal treatment of arteriosclerotic obstruction. Description of a new technique and preliminary report of its application. *Circulation* 30:654-670, 1964.
2. Grüntzig A, Hopff H: Perkutane Rekanalisation chronischer arterieller Verschlüsse mit einem neuen Dilatationskatheter. Modifikation der Dotter-Technik. *Dtsch Med Wschr* 99:2502-2505, 1974.
3. Seldinger SI: Catheter replacement of needle in percutaneous arteriography: A new technique. *Acta Radiol* 39:368, 1953.
4. Grüntzig A, Kumpke DA: Technique of percutaneous transluminal angioplasty with the Grüntzig balloon catheter. *Am J Radiol* 132:547-552, 1979.
5. Alpert RJ, et al: Treatment of vein graft stenosis by balloon catheter dilation. *JAMA* 242:2769-2771, 1979.
6. Zeidler E: Die perkutane Behandlung arterieller Obliterationen mit Kathetern, in Jebefer G, Rau G, Schoop W (eds): *Angiologie. Grundlagen Klinik und Praxis*, 2nd ed. Stuttgart, George Thieme Verlag, 1974, p. 298.
7. Grüntzig A, Bollinger A, Brunner U, Schlumpf M, and Wellauer J: Perkutane Rekanalisation chronischer arterieller Verschlüsse nach Dotter. Eine nichtoperative Katheter-technik. *Schweiz Med Wochenschr*. 103:825-831, 1973.
8. Katzen BT, Chang J, Knox GW: Percutaneous transluminal angioplasty with the Grüntzig balloon catheter. *Arch Surg* 114:1389-1399, 1979.
9. Wierny L, Plass R, Portsmann W: Long-term results in 100 consecutive patients treated by transluminal angioplasty. *Radiol* 112:543-548, 1974.



works well in your office . . .

NEOSPORIN® Ointment (polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.

- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.

- It contains three antibiotics that are rarely used systemically.

- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. FML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

The Difference Between Advertising And Marketing Is The Difference Between Distributing Aspirin And Practicing Medicine.

You can't cure every health problem with an aspirin, or every patient volume problem with a newspaper ad.

Media Methods offers you a tailor-made marketing program based on your problems, your needs, your budget and our 10 years of experience in health services marketing.

We've prescribed effective, economical treatment for private practitioners, professional associations, Medical/Dental staffs, health maintenance organizations, proprietary health care facilities and not-for-profit community hospitals.

Chances are we can help you.

For more details, send us the coupon below, or give us a call at (201) 335-8077.

MEDIA METHODS

339 Main Road, Montville, New Jersey 07045 (201) 335-8077

Please send me more information about your medical marketing services.

Name

Affiliation

Street

City State Zip

Business Phone

My interests include:

- | | |
|---|--|
| <input type="checkbox"/> Industrial/Occupational Health | <input type="checkbox"/> In-and-out Surgery |
| <input type="checkbox"/> Sports Medicine | <input type="checkbox"/> Affinity Group "Packages" |
| <input type="checkbox"/> Emergency Services | <input type="checkbox"/> Preventive Services |
| <input type="checkbox"/> Urgent Services | <input type="checkbox"/> Rehabilitative Services |

Mail to: Media Methods, 339 Main Rd., Montville, N.J. 07045

COLLECTION ON PAST DUE ACCOUNTS RECEIVABLE

HAMILTON AGENCY

924 Bergen Avenue
Jersey City, N.J. 07306
(201) 656-3232

INQUIRIES TO: J. GAINES

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

Transluminal Angioplasty of the Peripheral Vessels*

JOHN CHOLANKERIL, M.D., MANUEL ROWEN, M.D.,
FRANK GURAL, R.T., Elizabeth

Preliminary studies and short-term followup in six cases indicate that arterial dilatation as outlined by Grüntzig, Dotter and others is a procedure that can be a successful alternative to bypass surgery. The advantages of this technique include avoidance of general anesthesia and a major surgical procedure, and a shortened hospital stay. The technique can be repeated if necessary and future surgical intervention is not precluded if the method is unsuccessful.

Vascular stenosis and occlusion of the lower limbs (iliac, popliteal and femoral arteries) due to arteriosclerosis usually are treated by surgical bypass technique. However, in 1964, Dotter and Judkins¹ described transluminal dilatation of these lesions under direct x-ray supervision. Dotter¹ and Van Andel² used coaxial teflon catheters for gradual dilatation of atheromatous lesions. Grüntzig advanced this technique by the introduction of a catheter with an inflatable balloon at its tip to apply relatively high pressure to these plaques distending the lumen of the blood vessel.^{3,4} Modifications of this catheter have been used to dilate coronary, renal, iliac, femoral, and popliteal arteries. The technique has been improved to the point that it can be used effectively in a community hospital.

TECHNIQUE

Patients were selected who had a clinical history and physical evidence of occlusive vascular disease of the lower limbs demonstrable by x-ray.

1. **Femoral and popliteal arteries**—An antegrade puncture is made on the ipsilateral side and a 6.5F visceral catheter is introduced into the superficial femoral artery. Contrast material injected outlines the lesions which are delineated with metallic clips for future recognition. Preliminary angiography is performed. A soft "J" guide wire with a movable core is then passed through the compromised segment. If this is unsuccessful, the tip of the "J" wire is straightened using

the movable core and then carefully advanced for a short distance into the occlusion. The "J" tip configuration of the guide wire is then reformed and an attempt is made to advance the guide wire. If this fails, the catheter is advanced up to the lesion and a movable core "J" guide wire then is advanced through the catheter and the procedure repeated until the guide wire position reaches the distal segment. Occasionally a guide wire with a long tapered mandril may be used successfully to get beyond the occluded segment. During this guide wire manipulation, dilute contrast material is injected through a Y connector to make sure that no perforation or subintimal dissection has occurred. The visceral catheter then is passed over the guide wire and through the lesion. The balloon catheter then is exchanged for the visceral catheter. A 7F catheter with a 4mm. balloon is used in the femoral artery. Dilatation of the vessel is carried out by expanding the balloon with contrast media under fluoroscopic observation. Longer lesions are dilated segment by segment, the distal segment being dilated first. Three to five atmospheres of pressure are needed to inflate the balloon. The balloon is kept inflated for thirty to sixty seconds and may be repeated if necessary. A postoperative angiogram is performed. Contrast is aspirated from the balloon before the catheter is removed.

*From the Department of Radiology (Dr. Cholankeril and Mr. Gural) and Medicine (Dr. Rowen), St. Elizabeth Hospital, Elizabeth, NJ. Correspondence may be directed to Dr. Cholankeril at the hospital.

2. **Iliac vessels**—For ipsilateral iliac stenosis the balloon catheter is passed after a retrograde femoral puncture. For contralateral lesions a visceral catheter is advanced over the aortic bifurcation and a flexible, removable core "J" guide wire is advanced through the stenosis of the contralateral iliac artery. The balloon catheter then is passed over a heavy duty guide wire. A 9F catheter with 8mm. balloon for normal iliac vessels and 7F catheter with a 6mm. or 4mm. balloon for smaller vessels are used.

Twenty-four to forty-eight hours prior to dilatation the patient receives aspirin 600 mg twice a day or Persantine® 50 mg. three times a day or a combination of both. This is continued postoperatively for six months or an indefinite period to prevent platelet aggregation Heparin in a dose of 5,000 units is given during the procedure; "low-dose heparin" is administered for another three days post-operatively unless contraindicated.

Pressure measurements and pulse volume recordings by Doppler ultrasound or continuous recording plethysmography are obtained before and after the dilatation and then at successive followup visits.

MATERIALS AND METHODS

We have performed this technique on six patients. Case histories are presented below.

Case 1—An 84-year-old female was admitted to St. Elizabeth Hospital on October 16, 1979 because of cardiac arrhythmia, congestive heart failure and pain in the right leg associated with ulcerative gangrene of the large toe. She had fallen in February, 1979 and lacerated and bruised the right foot after which an infected ulcer formed on the right large toe. The ulcer was resistant to antibiotic therapy and the patient was admitted for treatment. There was no past history of diabetes mellitus, hypertension, pulmonary disease or gastrointestinal disease except for a cholecystectomy in 1976. She didn't smoke. The pertinent physical findings showed arteriosclerotic fundi, a grade III systolic aortic murmur and a diastolic grade II murmur over the left sternal border second interspace. Bilateral femoral pulsations were felt. The popliteal artery was palpable on the left, but absent on the right, dorsalis pedis and posterior tibial pulses were absent on the right with fair pulsations on the left. There was a necrotic ulcer measuring about two cm. in diameter with surrounding induration on the right first toe. The right foot was cool, slightly pale and clammy. Laboratory data revealed a WBC 15,500 and normal RBC; on the SMA chemical profile the blood sugar was elevated to 150 mg/dl. Electrolytes were normal. Chest x-ray showed cardiomegaly and emphysema. A right femoral arteriogram on October 18, 1979 showed three short stenotic lesions in the right superficial femoral artery (figure 1A). Dilatation of the lesions with Grüntzig balloon catheter was successful (figure 1B). The popliteal pulsations returned and the blood pressure reached 160 systolic. The ulcer on the large toe healed completely and the blue discoloration disappeared. She was discharged on November 11, 1979. Nine month followup revealed an asymptomatic lower limb with good popliteal and posterior tibial pulsations.

Case 2—A 54-year-old male smoker was admitted to St. Elizabeth Hospital on October 17, 1979. He came in because of a three-week history of increasing intermittent claudication involving his left leg more than his right with ischemic and cyanotic changes. The symptoms had been present for at least a year but became very severe recently. His physical examination revealed absent left femoral pulse. The right

femoral pulse was faint, but palpable. Cardiac status was normal. Laboratory study was done on admission: the SMA clinical profile was normal except for elevated glucose and cholesterol. A two-hour postprandial glucose was normal. Chest x-ray was essentially normal. Angiography showed a short stenotic lesion of the left common iliac artery with 80 percent narrowing of its original lumen (figure 2A). Another short lesion with 30 to 40 percent narrowing of the right common iliac artery also was found. The patient was advised that smoking would have to be terminated. He cooperated in this effort. Angioplasty of both common iliac arteries was performed (figure 2B) with good results. He has been able to return to full duty as a construction worker.

Case 3—A 57-year-old male was admitted to St. Elizabeth Hospital on January 12, 1980 because of intermittent claudication of the right leg of a few months' duration. He smoked 20 to 40 cigarettes daily and drank moderate amounts of alcohol. His past history revealed a partial gastrectomy in 1976 because of bleeding from a duodenal ulcer and recurrent gastritis due to alcohol ingestion. Physical examination: BP 150/90. Pulse 90. The head, neck, chest, lungs and heart were normal. The right femoral, popliteal, dorsalis pedis and posterior tibial pulses were not felt. The right foot was pale, with cyanosis but the left leg was normal. Hemogram, SMA/12 and electrolytes were normal. Arteriography revealed a 6.5 cm. occlusion of the right common femoral artery (figure 3A). On January 17, 1980 an angioplasty was performed with good results (figure 3B). Following the procedure the pain disappeared although the patient refused to stop smoking. He did not receive any aspirin or Persantine® postoperatively. A month later the patient's symptoms recurred. Angiography showed reocclusion of the dilated right common femoral artery lesion. Repeat angioplasty was unsuccessful. The patient had bypass surgery.

Case 4—A 77-year-old male was admitted to St. Elizabeth Hospital on May 15, 1980 complaining of severe bilateral claudication, more intense on the left side for the past year. Relevant history revealed a transient ischemic attack in 1978 for which he was prescribed aspirin. He does not have diabetes, arteriosclerotic heart disease, renal disease or gastrointestinal complaints. On physical examination the blood pressure was 138/64; the femoral pulses were normal, but neither popliteal pulse could be palpated. Abdominal aortogram and bilateral femoral arteriograms were performed. They showed 90 percent narrowing of a short distal segment of the left superficial femoral artery and 80 percent narrowing of a short segment of the distal superficial femoral artery on the right side. There were also one or two other areas of 50 percent narrowing of the superficial femoral arteries bilaterally. Bilateral femoral angioplasty was performed with good results. The patient was discharged and advised to take Persantine® and aspirin. After a month he became symptomatic on the left side and repeat angiography showed reocclusion of the left superficial femoral artery lesion. This lesion was redilated on June 19, 1980 and is normal at this writing.

Case 5—A 72-year-old, non-smoking, diabetic female was admitted to St. Elizabeth Hospital on May 20, 1980 because of gangrene of the left big toe extending to the dorsum of the foot. On physical examination her blood pressure was 160/80. Both femoral and the right popliteal arteries were palpable, but the left popliteal artery was not. Left femoral arteriography showed 99 percent narrowing of a short segment of the superficial femoral artery and 50 percent



Figure 1A—Stenotic lesions of the superficial femoral artery



Figure 1B—Dilatation of the lesions (arrows).



Figure 2A—Stenotic lesions of the common iliac arteries (arrows).

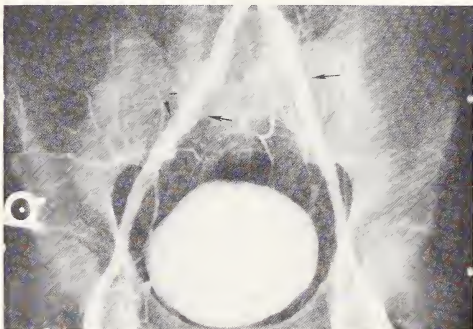


Figure 2B—Good dilatation of the lesions (arrows). Intimal cracks secondary to dilatation are also demonstrated (arrowhead).

narrowing of the popliteal artery above the trifurcation. Angioplasty was performed using Grüntzig balloon catheter. The patient was treated with full-dose heparin therapy for five days postangioplasty and developed an inguinal hematoma at the puncture site five days after the procedure. This was thought to be secondary to heparinization. The patient did well following angioplasty. The gangrene of the big toe demarcated and did not spread further. Amputation of the big toe was performed and the patient was discharged with advice to take Persantine®. She has remained symptom free for the last three months.

Case 6—A 66-year-old male smoker was admitted to St. Elizabeth Hospital on June 8, 1980. The patient was unable to walk more than two blocks for the last few months due to

increasing claudication in the left lower extremity. The patient was a diabetic for the last 25 years and took 40 units of N.P.H. daily. Physical examination revealed the blood pressure to be 135/86. The pulse was 90/min. Normal femoral, popliteal and dorsalis pedis pulsations were noted in the right lower extremity. Femoral pulse was not felt in left lower extremity. Review of other systems was unremarkable. Angiography showed a short stenotic lesion narrowing 95 percent of the original lumen of the left common iliac artery. There was a 20 cm. occlusive lesion of the proximal superficial femoral artery two cm. distal to its origin. The distal third of the superficial femoral artery and popliteal artery were normal and showed good filling through large collaterals from the normal left profunda femoris artery.



Figure 3A—This study shows a 6.5 cm. occlusion of the common femoral artery (arrow). A large collateral vessel from the hypogastric vessel also is demonstrated (arrowhead).

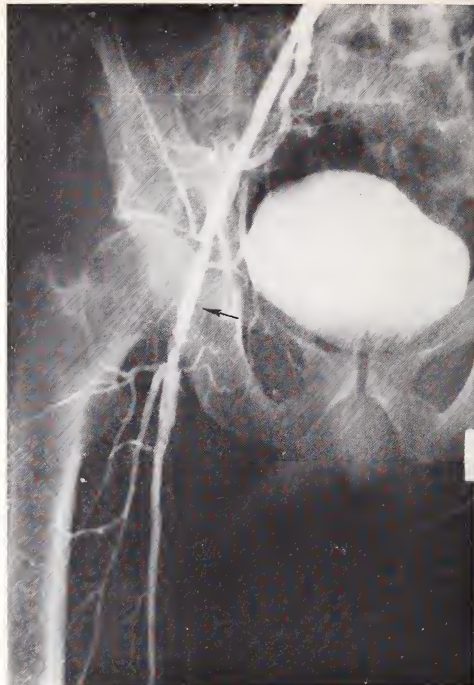


Figure 3B—After dilatation the occluded common femoral artery is well opened up (arrow). The collateral vessel also has disappeared.

Angioplasty of the left common iliac artery was performed on June 11, 1980. Since the collateral circulation filling the distal superficial femoral artery was adequate, the patient became asymptomatic. He is capable of walking as much as he wishes as of this writing.

COMPLICATIONS

Potential complications include local, intra- and retroperitoneal hematomas, arterial dissection and perforation, emboli (arteriosclerotic plaque or blood clot), false aneurysms, arterial thrombosis and difficulty in removal of the balloon. We encountered two local hematomas at the puncture site and one small subintimal dissection in our six cases. These complications in our patients did not cause any serious problems.

DISCUSSION

We successfully have dilated three common iliac arteries, one common femoral artery and four superficial femoral arteries in six patients with a minimum of untoward reactions. The success of transluminal angioplasty is hypothesized as resulting from compression of the rigid arteriosclerotic plaque against the arterial wall, widening the stenotic lumen.^{5,6} However, other authors believe the mechanism of dilatation is due to cracking of the intima so that the stretched media distends, carrying with it the intima and the atheromatous material⁸. Grüntzig and Kempe reported a patency rate of 87 percent for iliac artery stenosis and 72 percent for femoral popliteal lesions in 300 patients up to 24 months.³ Colapinto *et al.* reported a patency rate of 70

percent for iliac lesions and 50 percent for femoral-popliteal lesions in 94 patients up to 15 months after treatment.⁷ The difference in the results of these two large series is the criteria for patient selection and the experience of the investigator. Short, solitary stenosis and obstructions are technically easy to dilate and most likely to give good results. The procedure lends itself to relatively low cost, low morbidity and short hospital stay (3 to 4 days). An important advantage of dilatation of iliac vessels is that the danger of severing sympathetic fibers is avoided and innervation of genital function remains intact⁹. The procedure can be repeated and surgery still can be performed if dilatation is not successful. Patients with minimal to moderate disease who cannot be subjected to surgery are also ideal candidates for dilatation.

Case #1 had multiple small segmental lesions which were moderately calcified. Although Grüntzig cautions against heavily calcified lesions, we were able to dilate the artery and improve the circulation.^{3,4} Calcified lesions require maximum inflation pressures to obliterate the lesion and may also require multiple inflations. These results compare favorably with others who are applying this technique.¹⁰

Lesions longer than 10 cm. are poor candidates because they do not retain their patency after dilatation.^{3,4} Case 3 reoccluded one month after dilatation; he had a 6.5 cm.-long occluded right common femoral artery lesion. Smoking, failure to take aspirin and Persantine[®] and the length of the lesion may have been contributory factors in this case. However, some authors report success with longer lesions.¹⁰

Iliac artery occlusions are difficult to treat because of the difficulty in determining the course of the vessel in that

region; manipulation may result in perforation or bleeding into the peritoneal cavity and subintimal dissection. Patients with occluded iliac arteries are not candidates for balloon dilations.^{3,4} Arteriography performed immediately after dilatation may demonstrate longitudinal cracks (figure 3). These cracks probably represent small intramural dissection caused by distention of the fibrotic, stenotic vessel and have no significance in the result of the procedure.¹⁰

Smoking should be stopped and predisposing factors such as hypertension and hyperlipidemia should be treated before, and after transluminal angioplasty.³

SUMMARY

Our preliminary studies and short-term followup are favorable and confirm those reported by others. The addition of the Grüntzig balloon catheter to Dotter's original work has simplified the procedure and improved the results. The procedure is especially valuable when surgery is contraindicated or when symptoms are not considered severe enough to warrant surgery.

REFERENCES

1. Dotter CT, Judkins MP: Transluminal treatment of arteriosclerotic obstruction. Description of a new technique and a preliminary report of its applications. *Circulation* 30:654-670, 1964.
2. van Andel GJ: *Percutaneous Transluminal Angioplasty. The Dotter Procedure*. Amsterdam, Excerpta Medica, 1976.
3. Grüntzig A, Kempe DA: Technique of percutaneous transluminal angioplasty with the Grüntzig balloon catheter: *Am J Radiol* 132:547-552, 1979.
4. Grüntzig A: Die perkutane Rekanalisation chronischer arterieller Verchlüsse (Dotter-Prinzip) mit einem neuen doppelumigen Dilatationskatheter. *Fortschr Geb Roentgenstr Nuklearmed* (Eng abstr) 124:80-86, Jan 1976.
5. Dotter CT: Transluminal angioplasty—pathologic basis, in Zeitler E, Grüntzig A, Schoop W (eds): *Percutaneous Vascular Recanalisation*. Berlin, Springer, 1978, pp 3-12.
6. Len HJ, Grüntzig A.: *Histopathologic Aspects of Transluminal Recanalisation*. Berlin, Springer, 1978, pp 39-50.
7. Colapinto RF, Harries-Jones EP, Johnstone KW: Percutaneous transluminal dilatation and recanalization in the treatment of peripheral vascular disease. *Radiol* 135:583-587, (June) 1980.
8. Castaneda-Zuniga WR, Formanek A, Tadavarthy M, Vlodavay Z, et al: The mechanism of balloon angioplasty. *Radiol* 135:565-571, June 1980.
9. Van Andel GJ: Transluminal iliac angioplasty: Long-term results. *Radiol* 135:607-611, June 1980.
10. Freiman DB, Ring EJ, Olega JA, Berkowitz H, Roberts B: Transluminal angioplasty of the iliac, femoral and popliteal arteries. *Radiol* 132:285-288, 1979.

1. Dotter CT, Judkins MP: Transluminal treatment of

Diagnosis: obsolete patient billing procedures

Treatment: Universal Billing Systems

If your billing procedures haven't kept pace with your practice, it's time to talk to Universal Billing Systems. At Universal, we're specialists in computerized billing for the medical profession. Whether you're a solo practitioner or part of a group or clinical practice, we can customize a low-cost billing system to meet your exact needs. And we do it all! We print monthly statements and mail them directly to your patients. (The payments come to **you!**) We provide you with up-to-date **weekly** activity reports. Even eliminate the need for filling out time-consuming 3rd-party insurance forms. Universal Billing Systems can

- reduce labor costs
- increase billing efficiency
- speed cash flow
- eliminate billing delays caused by photocopying of bills and statements
- bring your patient billing system into the 80's

Best of all, your patients receive full details of every transaction including types of services rendered and types of payments received. This greatly reduces telephone inquiries to your office. And . . . your medical assistants require no special training to submit billing data to Universal. Write or phone for full details!



UNIVERSAL BILLING SYSTEMS

4 BANTA PLACE • HACKENSACK, N.J. 07601 • 487-8636

WE PUT YOUR REAL ESTATE INVESTMENT DOLLARS TO WORK FOR YOU!

Your best investment may be purchasing a condominium unit for rental purposes. We can find that exact investment property—the one that best suits your individual needs—no matter where it might be in the United States.

All across the nation, we search for condominium conversions and newly-constructed condominiums especially suitable for investment purposes. We research each project, then make our recommendations to you. Because we're there at the conception of the conversion or construction, you buy the properties at the original and lowest prices.

- We arrange for the purchase of the condominium
- We aid in obtaining your financing
- We carefully screen and find tenants for your condominium
- We arrange management of the unit for you
- WE SEE THAT YOUR DOLLARS ARE WORKING FOR YOU!

We handle the investment transaction from beginning to end. And as your representative, we minimize the responsibilities of ownership. You just enjoy the advantages:

- 100% ownership
- Appreciation of investment unit
- Obvious tax breaks—depreciation on rental property, interest and property tax deductions
- At sale, your profit is capital gains, not ordinary income

Write or call Skyline Associates for more information. A representative will contact you with everything you need to know about our services.

Skyline Associates, Inc.
72 Hickory Road
Ringwood, New Jersey 07456
201/962-6300

Please contact me with additional information about condominium investments and the services you provide.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

A New Gastropasty for Reflux Esophagitis*

NICHOLAS J. DEMOS, M.D., Jersey City

The application of our standard method of operative correction of hiatal hernia is detailed in the treatment of complicated cases of reflux esophagitis. A stapled uncut gastropasty and plication are performed. A critique of currently used methods and results are detailed. Eight-year, followup data have added to our confidence in performing the operation.

Encouraged by the constancy of our success with our previously reported simplified stapling, uncut gastropasty for reflux esophagitis,² we have applied the same technique in complicated cases of gastroesophageal reflux with severe esophagitis. Such cases include short esophagus with irreducible and strictured cardia, severe reflux occurring after generous subtotal gastrectomy, reflux of the esophagogastritis of scleroderma or lupus, paraesophageal hernias and Barrett's esophagus with or without high esophageal stricture.

MATERIAL AND RESULTS

We have applied our technique to over 65 patients in the last seven and a half years. There have been 41 women and 24 men, ranging in age from 19 to 78 years of age. The mortality has been zero. Fifty patients were followed from two to seven and a half years. Morbidity includes intercostal neuralgia in 23 patients which lasted a few weeks to a few months but responded to mild analgesic medication and/or reassurance.

Postprandial left upper-quadrant ache or "gas bloat" syndrome, lasting one to two hours, was present in eleven patients but it never lasted more than two months. The most distressing morbidity was gastric stasis which occurred in two women (Table I). Postoperatively, the first patient stopped vomiting but kept "retching" for several months. A gastroenterostomy was performed out of desperation and

completely cured her symptoms. She gained 15 pounds in weight and remains asymptomatic six years later. The second woman had gastric stasis four to six hours after barium ingestion, as demonstrated by preoperative gastrointestinal x-rays. Twelve days after hiatal hernioplasty and gastropasty a pyloroplasty had to be performed to completely alleviate all of her symptoms. She gained five pounds in the next few weeks.

A 19-year-old man was examined three and a half years after surgery; he complained of epigastric and low substernal pain. He was a bar tender and consumed a large amount of alcohol daily. Esophageal motility studies revealed a 12 mm Hg lower esophageal pressure but good peristalsis. Proper diet, antacids and avoidance of alcohol subsequently controlled his symptoms for one year.

Weight loss has not been a constant preoperative finding. Many patients have gained weight from excessive ingestion of food and milk, which apparently gave temporary relief of symptoms. However, there were six quite emaciated patients, including those with stricture; this group uniformly gained weight after surgery and were the most grateful patients in the entire series.

*From the New Jersey Medical School, CMDNJ, Newark where Dr. Demos is Associate Clinical Professor of Surgery, and the Esophageal Physiology Laboratory of Christ Hospital, Jersey City, New Jersey which is supported in part by the James Nicholas Surgical Research Fund. Correspondence may be addressed to N.J. Demos, M.D., 921 Bergen Avenue, Jersey City, N.J. 07306.

Table 1

Morbidity	Number
Intercostal neuralgia, mild	23
Gas bloating syndrome, transient	11
Gastric stasis	2
Symptoms of chest pain	1

ILLUSTRATIVE CASE REPORTS AND TECHNIQUE

Case 1—A 77-year-old, vigorous-looking woman had been suffering from epigastric and substernal pain and burning for five to six years. The pain radiated to both sides of the chest. Previous history included angina pectoris, an "old myocardial infarction" and a right carotid endarterectomy.

Esophagram and gastrointestinal x-rays revealed a "very short esophagus, a large hiatal hernia and gastroesophageal reflux" (Figures 1 and 2a). Fiberoptic esophagoscopy revealed the cardia at 26 centimeters from the incisors. A patulous cardia was severely inflamed and barely admitted the flexible esophagoscope. Gastric mucosa covered the esophagus up to 2.5 centimeters superior to the cardia. A large hiatal hernia was present with free gastroesophageal reflux.

At operation the chest was entered through the left seventh intercostal space. The cardia was near the inferior margin of the aortic arch. There was a tubular herniation of the proximal stomach into the mediastinum. The herniated stomach received several segmental arteries transversely from the thoracic aorta. These vessels were not disturbed. Part of the infradiaphragmatic stomach was mobilized through the already enlarged hiatus and brought up into the chest without dividing any short gastric vessels. Several number one silk sutures were inserted around both sides of the diaphragmatic hiatus posterior to the stomach, but were not tied. At the level of the stomach which was previously at the hiatus, the TA-55 stapler was used to insert a double row of staples on the fundus opposite and parallel to the lesser curvature thereby creating a tubular prolongation of the dissected part of the stomach (Figure 2b). The redundant fundus was plicated around the newly formed tubular seg-

ment, placing it easily under the diaphragm. A few sutures were placed through the upper margin of the plicated stomach. Both ends of each suture were passed through the nearby diaphragm through separate needles and tied on the superior surface of the diaphragm. The crural sutures were now tied (Figure 2c). The chest was closed after intercostal tube insertion.

Cardiac arrhythmia occurring three days after the operation responded to medications. Postoperative esophagram revealed competence (Figure 3). The patient has remained well for over five years.

Case 2—A 65-year-old man was suffering from constant severe retrosternal pain and burning for two years. The pain radiated to both sides of the chest and to the low thoracic spine. Past medical history included subtotal gastrectomy for peptic ulcer nine years previously and right upper lobectomy for cavitary tuberculosis with hemoptysis two years previously. (See Figures 4 and 5 for pre and postoperative esophagrams). He has been well for over five years.

Case 3—A 69-year-old man had lower chest pain for four years. Dysphagia and retrosternal pain were present for two months and only partly responded to antacids. Esophagram revealed a paraesophageal hernia (Figure 6). Postoperative esophagram is seen in Figure 7.

Additional Cases—Two patients had Barrett's esophagus and suffered from severe long-standing substernal pain and dysphagia. On endoscopy, one had a four millimeter stricture above the aortic arch. The other patient had strictured cardia; the lower esophageal mucosa was hemorrhagic, ulcerated and in areas necrotic. On biopsy, they both had columnar epithelium extending up to 18 and 10 centimeters above the cardia respectively; this established the diagnosis of Barrett's esophagus. Both patients underwent trans-thoracic stapling gastroplasty and fundoplication. Both had preoperative and one had one postoperative dilatation. They have remained well three and two years postoperatively.

Three patients with collagen disease were operated on six years, two years and three months ago and are now asymptomatic.

One of the most fascinating patients was a 45-year-old



Figure 1—Preoperative esophagram showing a very short esophagus with strictured cardia in the mid-chest.

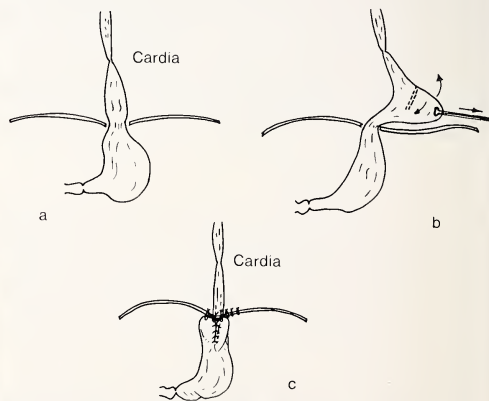


Figure 2—(a) Sliding hiatal hernia and severely short esophagus. This cardia is irreducible below the diaphragm. (b) A segment of the infradiaphragmatic gastric fundus is dissected and brought up in the chest where uncut stapling and fundoplication are performed. (c) The valve mechanism has been placed under the diaphragm. The plicated stomach is sutured to the diaphragm and the crural sutures have been tied.



Figure 3—Postoperative esophagram showing absence of hiatal hernia or reflux and a competent lower segment.

man who was legally disabled for "heart disease" and "chest pain" for five years. Two cardiac catheterizations were completely normal four and two years previously. In spite of nitrites and beta-blocking agents he was rushed to the emergency room at night every few weeks because of "chest pain." Close questioning revealed reflux type of symptoms and almost constant burping. Esophagoscopy revealed a patulous cardia. Esophagram showed a small hiatal hernia. Esophageal motility and pH studies revealed a normal lower esophageal sphincter pressure, but lack of peristaltic waves with 80 percent of disordered motor activity (Figure 8). The pH remained less than five for 15 cm. above the lower sphincter and his symptoms were reproduced spontaneously with retching while the pH decreased to 1.5 to 2 in the mid-esophageal level. After surgical correction of his reflux, the patient has remained asymptomatic for one year.



Figure 4—Preoperative barium swallow in patient two who had a subtotal gastrectomy nine years previously.



Figure 5—See competence of gastroesophageal sphincter postoperatively. Note the adequate gastric remnant, even after stapling gastropasty.

DISCUSSION

While Nissen's principle of fundoplication was a most important advance in the repair of hiatal hernia,⁹ the Collis gastropasty put forth an important principle in the repair of



Figure 6—"Upside-down" stomach in a paraesophageal hernia.

a very shortened esophagus with irreducible cardia.¹ Separate examination of each of these two principles follows.

Nissen's fundoplication produces a soft, cushioned collapse of the lowermost esophagus and cardia. The resulting pressure is adequate to prevent gastroesophageal reflux. Recurrences are most likely caused by the tendency of the esophagus to pull upward by the longitudinal muscular contraction, and the negative intrathoracic and positive intra-abdominal pressures. This upward pulling has in some patients made the fundoplication slip down so far around the stomach as to produce an hour-glass constriction, with symptomatic relapse, according to Woodward.¹⁴ He advises fixation of the plicated stomach to the esophageal wall, but those esophageal sutures might have been the cause of fatal infection by fistula formation in two of his cases.

On the other hand, esophageal wall sutures are notoriously insecure and ineffective in preventing upward displacement of the esophagus and recurrence of reflux. In our technique esophageal sutures are never necessary to prevent unfolding. There is anatomic continuity of the plicating fundus and plicated gastric segment²⁻⁴ (Figure 2).

In the Hill technique of plication⁸ no sutures are advised between the stomach and the esophagus, although Woodward advises esophageal sutures because of his high recurrence rate with the Hill technique.¹⁴ Moreover, Vansant, Baker and Ross have found it necessary to modify Hill's technique by performing a dangerously complicated dissection; they introduced terms such as "esophagophrenic bundles" in attempting to improve the technique.¹³

The Belsey Mark IV technique is a partial fundoplication. The high recurrence of the partial fundoplications has been recorded honestly. It has been inadequate to cure the patients with stricture, especially those with short esophagus.^{10,12} Skinner proposed full circumferential fundoplication for the strictured esophagus.¹² He also advised suturing the esophagus with the fundoplicating sutures to prevent upward esophageal displacement, but he did not state how successful those esophageal sutures were in the prevention of upward migration of the esophagus in his three recurrent cases.



Figure 7—Normal position of stomach, and comfortably long fundoplicated esophagogastric junction, after the stapling gastroplasty, (arrow).

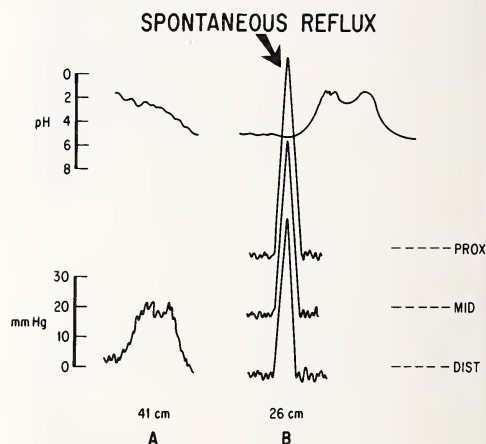


Figure 8—Preoperative esophageal function study on patient with "chest pains."

a. Normal pressure and almost normal pH inversions from stomach to esophagus.

b. Simultaneous high pressure esophageal contractions during retching associated with acid reflux pH curve and reproduction of symptoms. Similar pH curve and symptoms were reproduced on acid perfusion study.

"Recurrences are most likely caused by the tendency of the esophagus to pull upward by the longitudinal muscular contraction . . ."

Severely short esophagus was treated by Collis by transposing the anatomic new cardia lower down under the diaphragm by incising the fundus parallel to the lesser curvature.¹ The technique was not uniformly successful in preventing reflux. Fundoplication has been added to the prolongation of the esophagus in order to form a one-way valve.¹⁰ In essence, a 14 to 20 centimeter suture line is created to prolong the esophagus. The esophageal prolongation then is resutured to the divided fundus, and the fundus is plicated to a variable length of the prolongation.

One immediately can see the futility of dividing the stomach because the divided fundus is again reattached to the tubular fundic segment. Moreover, the necessity of this extensive surgical creation of an esophageal prolongation recently has been questioned by others.³ Our technique has introduced simple stapling of the fundus parallel to the lesser curvature thus not only creating a prolongation of the esophagus but also avoiding the necessity of incising and resuturing the stomach to itself. The wrapping is performed lower down, thus avoiding extensive mobilization of the esophagus leading to ischemia and leakage.¹¹

An additional problem now arises in the very short esophagus. If the esophagus is extensively dissected from the mediastinum, necrosis of the wall from ischemia or from tacking down sutures to prevent upward displacement can occur. This may lead to fatality as occurred in one of Polk's cases.¹¹ In one patient reported by Woodward the wrapped stomach was left in the chest with good result for many years.¹⁴ Two such cases with lesser followup have been reported by Herrington and his colleagues.⁷ Strangulation of the stomach and pressure ulcers, the so-called "riding ulcers," may occur at the point the diaphragm surrounds the chestward-displaced stomach.

For these reasons, in the severely shortened esophagus, we decided to produce the valvular mechanism below the diaphragm but without incising the gastric fundus (Figures 1 and 2).

In our technique no sutures have to be taken on the esophagus and the valve mechanism remains below the diaphragm. The plicated tubular segment cannot slip upward because of its anatomic continuity to the plicating stomach.

The second case illustrates that our technique may be applied successfully in the small gastric remnant since it uses only a small portion of the fundus, unlike the more extensive procedure of incising, suturing and reattaching the fundus to itself. It would seem to us that more extensive procedures such as an additional gastric reservoir fashioned from jejunum as reported by Ellis might not be necessary in all cases.⁶

In the case of the patients with massive paraesophageal hernias (Figures 6 and 7), the added protection of our uncut, stapling gastroplasty and plication assures the patient against a loose hypotensive sphincter. Our patient had preoperative

symptoms suggestive of reflux esophagitis. Moreover, the entire valvuloplasty usually takes no longer than ten minutes to perform.

The patients with Barrett's esophagus presented special cases of reflux esophagitis. In addition to the severe and extensive inflammation of an extensive segment of the esophagus, the presence of columnar epithelium was ascertained. Creation of an infradiaphragmatic valvuloplasty cured the symptoms and stopped further inflammatory changes in the columnar and in the squamous-lined esophagus. Similar benefit has been derived from infradiaphragmatic valvuloplasty in patients with scleroderma or lupus erythematosus as well as in patients with recurrence of symptoms, after various other procedures for reflux had been performed elsewhere and had failed.

Currently we perform motility and pH studies on almost all of our patients. These studies, however, are of greatest usefulness in the investigation of atypical symptoms of reflux such as postprandial fullness, belching, choking, angina-like chest pain, hoarseness, dyspnea, wheezing and chronic cough. The last patient described above had become a burden on society and his family as well as a cardiac therapeutic failure. Esophageal function studies proved that his symptoms were caused by reflux of acid into his esophagus. Our gastroplasty has kept him asymptomatic for one year.

Fifty patients have been followed for two to over seven years. Zero mortality and low morbidity make our technique quite acceptable. No anatomic recurrence has been seen. Recurrent complaints are usually due to disturbances in other organ systems. Alcoholic gastritis has been a problem. Severely emaciated patients have had weight gain, but many patients have gained weight preoperatively by increased eating and milk ingestion in order to relieve their symptoms.

SUMMARY

The benefits of a new, safe, fast and consistently successful gastroplasty have been combined with fundoplication. Successful application of the technique has been observed in difficult and atypical cases. The reflux of an irreducible cardia of congenitally short esophagus, postgastrectomy reflux, paraesophageal hernia, Barrett's esophagus and collagen esophagus have been handled easily with the new stapling, uncut gastroplasty and fundoplication.

Our technique has proved superior (in our hands) to other currently available ones. We have had no mortality and no recurrence in over 65 patients treated over a seven and a half year period.

The usefulness of esophageal function tests was demonstrated, especially in patients who have atypical and misleading symptoms of esophagitis. The latter usually implicates other organ systems erroneously.

"Our technique has introduced simple stapling of the fundus parallel to the lesser curvature . . ."

" . . . motility and pH studies . . . are of greatest usefulness in the investigation of atypical symptoms of reflux. . . ."

REFERENCES

1. Collis JL, in Rob C and Smith R (eds): *Benign Obstruction of the Esophagus Excluding Cardiospasm in Clinical Surgery*. London, Butterworth, 1964.
2. Demos NJ: A simplified improved technique for the Collis gastroplasty for dilatable esophageal strictures. *Surg Gynecol Obstet* 142:591, 1976.
3. Demos NJ, Smith N, Williams D: A gastroplasty for short esophagus and reflux esophagitis: Experimental and clinical studies. *Ann Surg* 181:178, 1975.
4. Demos NJ, Smith N, Williams D: A new gastroplasty for strictured short esophagus. *N Y State J Med* 75:57, 1975.
5. Editorial, *Yearbook of Surgery*. Chicago, Yearbook Medical Publishers, 1977, p. 26.
6. Ellis FH Jr: Fundoplication for hypotensive lower esophageal sphincter after gastrectomy. *Surg Gynecol Obstet* 145:430, 1977.
7. Herrington JL Jr, Wright RS, Edwards WH, Sawyers JL: Conservative surgical treatment of reflux esophagitis and esophageal stricture. *Ann Surg* 181:552, 1975.
8. Hill LD: An effective operation for hiatal hernia: An eight-year appraisal. *Ann Surg* 166:681, 1967.
9. Nissen R: Gastropepy and fundoplication in surgical treatment of hiatal hernia. *Am J Dig Dis* 6:954, 1961.
10. Orringer MB, Skinner DB, Belsey RHR: Long-term results of the Mark IV operation for hiatal hernia and analyses of recurrences and their treatment. *J Thorac Cardiovas Surg* 63:25, 1972.
11. Polk HC: Fundoplication for reflux esophagitis: Misadventures with the operation of choice. *Ann Surg* 183:645, 1976.
12. Skinner DB: Benign esophageal strictures. *Adv Surg* 10:189, 1976.
13. Vansant JH, Baker JW, Ross DG: Modification of the Hill technique for repair of hiatal hernia. *Surg Gynecol Obstet* 143:637, 1976.
14. Woodward ER: Discussion of reference #11, p. 651.

Housing Application—Meadowlands Hilton Annual Meeting, MSNJ—May 15-19, 1981

Please Reserve: _____ Single _____ Double _____ Twin _____ Suite

Arrival: (date) _____ at (time) _____

Departure: (date) _____ at (time) _____

Name _____

Address _____

City _____ State _____ Zip Code _____

If double or twin name of person joining _____

Single: \$56

Twin: \$67

Double: \$67

Suite: \$150 and up

If range of rates is offered and rate requested is not available, the next available rate will be assigned. Reservations must be received no later than two (2) weeks prior to the opening date of your meeting and will be held until 6 p.m. on day of arrival unless otherwise specified.

(New Jersey Sales Tax - 5%)

Complete and mail this application to: Front Office Manager
The Meadowlands Hilton
Two Harmon Plaza
Secaucus, New Jersey 07094

COMPARE OUR PREMIUM RATES!

\$500,000

**ANNUAL RENEWABLE &
CONVERTIBLE TERM INSURANCE**

Age	Initial Premium
35	\$ 595
40	795
45	1,110
50	1,595
55	2,480
60	3,845

Minimum policy \$100,000

CALL OR HAVE
YOUR BROKER CALL

N.Y.C.

(212) 687-0031

N.J.

(201) 947-3100



THE INSURANCE
SUPERMARKET, INC.
RIDGEFIELD, N.J. 07657



**Lupus Erythematosus Foundation
of New Jersey
201 — 791-7868**

*Research — Service — Education in Lupus Erythematosus
Serving New Jersey Since 1976*

**GRANTS FOR RESEARCH INTO
LUPUS ERYTHEMATOSUS**

Research activities in New Jersey only

**Information For Applicants
Some Grants up to \$10,000 are available**

Form of Application:

May be obtained after January 10th by writing to:

Mr. E. Youngsman, *Research Grants Coordinator*
Lupus Erythematosus Foundation of N.J.
Post Office Box 320
Elmwood Park, New Jersey 07407

Deadline for Application: April 1, 1981

Please submit 6 copies of completed application

Grants will be awarded as of May 1, 1981

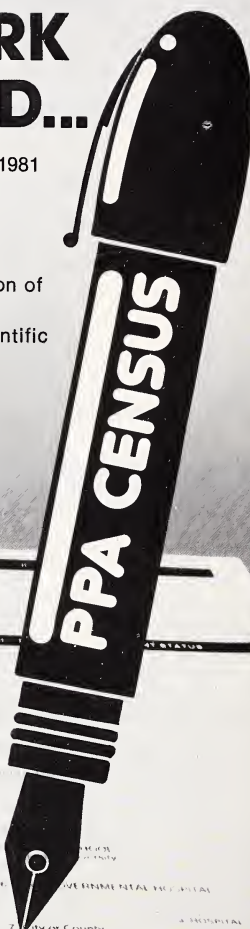
MAKE YOUR MARK AND BE COUNTED...

If you haven't already, now is the time to complete the 1981 Census of Physicians' Professional Activities.

Doing so will assure:

- that your official record is updated
- that you are accurately represented in the 28th Edition of the *American Medical Directory*
- that you continue to receive the educational and scientific materials relevant to your professional interests

Call or write if you have not received a census form
Division of Survey & Data Resources
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
312-751-6435



1. How many hours per week do you spend on DIRECT CARE OF PATIENTS?

2. How many hours per week do you spend on OTHER MEDICAL ACTIVITIES?

3. How many hours per week do you spend on MEDICAL TEACHING?

4. How many hours per week do you spend on MEDICAL RESEARCH?

5. How many hours per week do you spend on other medical activities (not listed above) involving DIRECT CARE OF PATIENTS?

6. How many hours per week do you spend on OTHER MEDICAL ACTIVITIES (not listed above) NOT involving care of patients?

7. How many hours per week do you spend in ALL PROFESSIONAL ACTIVITIES? For Residents, this is the total of questions 1, 5 and 7. For all other physicians this is the total of questions 2-7.

8. Indicate Federal Agency

9. U.S. Government

10. OTHER ORGANIZATION

11. Indicate Federal Agency

12. U.S. Government

13. Veterans Administration

14. Other

15. Other

16. Other

17. Other

18. Other

19. Other

20. Other

21. Other

22. Other

23. Other

24. Other

25. Other

26. Other

27. Other

28. Other

29. Other

30. Other

31. Other

32. Other

33. Other

34. Other

35. Other

36. Other

37. Other

38. Other

39. Other

40. Other

41. Other

42. Other

43. Other

44. Other

45. Other

46. Other

47. Other

48. Other

49. Other

50. Other

51. Other

52. Other

53. Other

54. Other

55. Other

56. Other

57. Other

58. Other

59. Other

60. Other

61. Other

62. Other

63. Other

64. Other

65. Other

66. Other

67. Other

68. Other

69. Other

70. Other

71. Other

72. Other

73. Other

74. Other

75. Other

76. Other

77. Other

78. Other

79. Other

80. Other

81. Other

82. Other

83. Other

84. Other

85. Other

86. Other

87. Other

88. Other

89. Other

90. Other

91. Other

92. Other

93. Other

94. Other

95. Other

96. Other

97. Other

98. Other

99. Other

100. Other

101. Other

102. Other

103. Other

104. Other

105. Other

106. Other

107. Other

108. Other

109. Other

110. Other

111. Other

112. Other

113. Other

114. Other

115. Other

116. Other

117. Other

118. Other

119. Other

120. Other

121. Other

122. Other

123. Other

124. Other

125. Other

126. Other

127. Other

128. Other

129. Other

130. Other

131. Other

132. Other

133. Other

134. Other

135. Other

136. Other

137. Other

138. Other

139. Other

140. Other

141. Other

142. Other

143. Other

144. Other

145. Other

146. Other

147. Other

148. Other

149. Other

150. Other

151. Other

152. Other

153. Other

154. Other

155. Other

156. Other

157. Other

158. Other

159. Other

160. Other

161. Other

162. Other

163. Other

164. Other

165. Other

166. Other

167. Other

168. Other

169. Other

170. Other

171. Other

172. Other

173. Other

174. Other

175. Other

176. Other

177. Other

178. Other

179. Other

180. Other

181. Other

182. Other

183. Other

184. Other

185. Other

186. Other

187. Other

188. Other

189. Other

190. Other

191. Other

192. Other

193. Other

194. Other

195. Other

196. Other

197. Other

198. Other

199. Other

200. Other

201. Other

202. Other

203. Other

204. Other

205. Other

206. Other

207. Other

208. Other

209. Other

210. Other

211. Other

212. Other

213. Other

214. Other

215. Other

216. Other

217. Other

218. Other

219. Other

220. Other

221. Other

222. Other

223. Other

224. Other

225. Other

226. Other

227. Other

228. Other

229. Other

230. Other

231. Other

232. Other

233. Other

234. Other

235. Other

236. Other

237. Other

238. Other

239. Other

240. Other

241. Other

242. Other

243. Other

244. Other

245. Other

246. Other

247. Other

248. Other

249. Other

250. Other

251. Other

252. Other

253. Other

254. Other

255. Other

256. Other

257. Other

258. Other

259. Other

260. Other

261. Other

262. Other

263. Other

264. Other

265. Other

266. Other

267. Other

268. Other

269. Other

270. Other

271. Other

272. Other

273. Other

274. Other

275. Other

276. Other

277. Other

278. Other

279. Other

280. Other

281. Other

282. Other

283. Other

284. Other

285. Other

286. Other

287. Other

288. Other

289. Other

290. Other

291. Other

292. Other

293. Other

294. Other

295. Other

296. Other

297. Other

298. Other

299. Other

300. Other

301. Other

302. Other

303. Other

304. Other

305. Other

306. Other

307. Other

308. Other

309. Other

310. Other

311. Other

312. Other

313. Other

314. Other

315. Other

316. Other

317. Other

318. Other

319. Other

320. Other

321. Other

322. Other

323. Other

324. Other

325. Other

326. Other

327. Other

328. Other

329. Other

330. Other

331. Other

332. Other

333. Other

334. Other

335. Other

336. Other

337. Other

338. Other

339. Other

340. Other

341. Other

342. Other

343. Other

344. Other

345. Other

346. Other

347. Other

348. Other

349. Other

350. Other

351. Other

352. Other

353. Other

354. Other

355. Other

356. Other

357. Other

358. Other

359. Other

360. Other

361. Other

362. Other

363. Other

364. Other

365. Other

366. Other

367. Other

368. Other

369. Other

370. Other

371. Other

372. Other

373. Other

374. Other

375. Other

376. Other

377. Other

378. Other

379. Other

380. Other

381. Other

382. Other

383. Other

384. Other

385. Other

386. Other

387. Other

388. Other

389. Other

390. Other

391. Other

392. Other

393. Other

394. Other

395. Other

396. Other

397. Other

398. Other

399. Other

400. Other

401. Other

402. Other

403. Other

404. Other

405. Other

406. Other

407. Other

408. Other

409. Other

410. Other

411. Other

412. Other

413. Other

414. Other

415. Other

416. Other

417. Other

418. Other

419. Other

420. Other

421. Other

422. Other

423. Other

424. Other

425. Other

426. Other

427. Other

428. Other

429. Other

430. Other

431. Other

432. Other

433. Other

434. Other

435. Other

436. Other

437. Other

438. Other

439. Other

440. Other

441. Other

442. Other

443. Other

444. Other

445. Other

446. Other

447. Other

448. Other

449. Other

450. Other

451. Other

452. Other

453. Other

454. Other

455. Other

456. Other

457. Other

458. Other

459. Other

460. Other

461. Other

462. Other

463. Other

464. Other

465. Other

466. Other

467. Other

468. Other

469. Other

470. Other

471. Other

472. Other

473. Other

474. Other

475. Other

476. Other

477. Other

478. Other

479. Other

480. Other

481. Other

482. Other

483. Other

484. Other

485. Other

486. Other

487. Other

488. Other

489. Other

490. Other

491. Other

492. Other

493. Other

494. Other

495. Other

496. Other

497. Other

498. Other

499. Other

500. Other

501. Other

502. Other

503. Other

504. Other

505. Other

506. Other

507. Other

508. Other

509. Other

510. Other

511. Other

512. Other

513. Other

514. Other

515. Other

516. Other

517. Other

518. Other

519. Other

520. Other

521. Other

522. Other

523. Other

524. Other

525. Other

526. Other

527. Other

528. Other

529. Other

530. Other

531. Other

532. Other

533. Other

534. Other

535. Other

536. Other

537. Other

538. Other

539. Other

540. Other

541. Other

542. Other

543. Other

544. Other

545. Other

546. Other

547. Other

548. Other

549. Other

550. Other

551. Other

552. Other

553. Other

554. Other

555. Other

556. Other

557. Other

558. Other

559. Other

560. Other

561. Other

562. Other

563. Other

564. Other

565. Other

566. Other

567. Other

568. Other

569. Other

570. Other

571. Other

572. Other

573. Other

574. Other

575. Other

576. Other

577. Other

578. Other

579. Other

580. Other

581. Other

582. Other

583. Other

584. Other

585. Other

586. Other

587. Other

588. Other

589. Other

590. Other

591. Other

592. Other

593. Other

594. Other

595. Other

596. Other

597. Other

598. Other

599. Other

600. Other

601. Other

602. Other

603. Other

604. Other

605. Other

606. Other

607. Other

608. Other

609. Other

610. Other

611. Other

612. Other

613. Other

614. Other

615. Other

616. Other

617. Other

618. Other

619. Other

620. Other

621. Other

622. Other

623. Other

624. Other

625. Other

626. Other

627. Other

628. Other

629. Other

630. Other

631. Other

632. Other

633. Other

634. Other

635. Other

636. Other

637. Other

638. Other

639. Other

640. Other

641. Other

642. Other

643. Other

644. Other

645. Other

646. Other

647. Other

648. Other

649. Other

650. Other

651. Other

652. Other

653. Other

654. Other

655. Other

656. Other

657. Other

658. Other

659. Other

660. Other

661. Other

662. Other

663. Other

664. Other

665. Other

666. Other

667. Other

668. Other

669. Other

670. Other

671. Other

672. Other

673. Other

674. Other

675. Other

676. Other

677. Other

678. Other

679. Other

680. Other

681. Other

682. Other

683. Other

684. Other

685. Other

686. Other

687. Other

688. Other

689. Other

690. Other

691. Other

692. Other

693. Other

694. Other

695. Other

696. Other

697. Other

698. Other

699. Other

700. Other

701. Other

702. Other

703. Other

704. Other

705. Other

706. Other

707. Other

708. Other

709. Other

710. Other

711. Other

712. Other

713. Other

714. Other

715. Other

716. Other

717. Other

718. Other

719. Other

720. Other

721. Other

722. Other

723. Other

724. Other

725. Other

726. Other

727. Other

728. Other

729. Other

730. Other

731. Other

732. Other

733. Other

734. Other

735. Other

736. Other

737. Other

738. Other

739. Other

740. Other

741. Other

742. Other

743. Other

744. Other

745. Other

746. Other

747. Other

748. Other

749. Other

750. Other

751. Other

752. Other

753. Other

754. Other

755. Other

756. Other

757. Other

758. Other

759. Other

760. Other

761. Other

762. Other

763. Other

764. Other

765. Other

766. Other

767. Other

768. Other

769. Other

770. Other

771. Other

772. Other

773. Other

774. Other

775. Other

776. Other

777. Other

778. Other

779. Other

780. Other

781. Other

782. Other

783. Other

784. Other

785. Other

786. Other

787. Other

788. Other

789. Other

790. Other

791. Other

792. Other

793. Other

794. Other</

CASE REPORTS

Oral Phosphates Treatment of Hypercalcemia in Pregnancy*

HOWARD A. LEVY, M.D., LOUIS PIERUCCI, M.D., and
PAUL STROUP, M.D., Camden

When surgery appeared inadvisable, medical therapy with oral phosphates successfully corrected hypercalcemia due to a functioning parathyroid adenoma in a pregnant patient. After a normal delivery free of neonatal tetany, surgery was successfully performed. An alternate medical program for hypercalcemia in pregnancy is suggested.

Untreated hyperparathyroidism in pregnancy has resulted in high fetal and neonatal mortality and morbidity.^{1,2} Parathyroidectomy during the second trimester recently has been recommended as the best treatment for this problem.^{3,4} This report describes a successful medical therapy for hypercalcemia due to hyperparathyroidism in a patient in whom surgery was not considered urgent.

CASE REPORT

A 31-year-old female was hospitalized in October 1974, for palpitations and dyspnea mid-way through the third trimester of her fourth pregnancy. Her previous pregnancies were uneventful. A year earlier she was treated medically for a duodenal ulcer, and in April 1974, a healed ulcer crater was noted on x-ray. There was a family history of diabetes.

During her hospitalization earlier in the pregnancy for pyelonephritis, a serum calcium of 12.9 mg/dl and a phosphate of 1.7 mg/dl were noted. She denied all symptoms of hyperparathyroidism. Office laboratory studies included a hemoglobin of 11.7 gm/dl, Rh positive group B, and a Class 1 pap smear.

Physical examination revealed a well-developed, mildly obese female in no overt distress. Blood pressure was 130/80, pulse 110, respirations 16, temperature 98.2°F. Positive findings included mild pallor of the mucosae, an S-4 gallop sound, and a Grade II blowing apical systolic murmur. P2 was prominent and was physiologically split. The uterus was

enlarged to three finger breadths above the umbilicus, which was consistent with the gestational age.

LABORATORY STUDIES

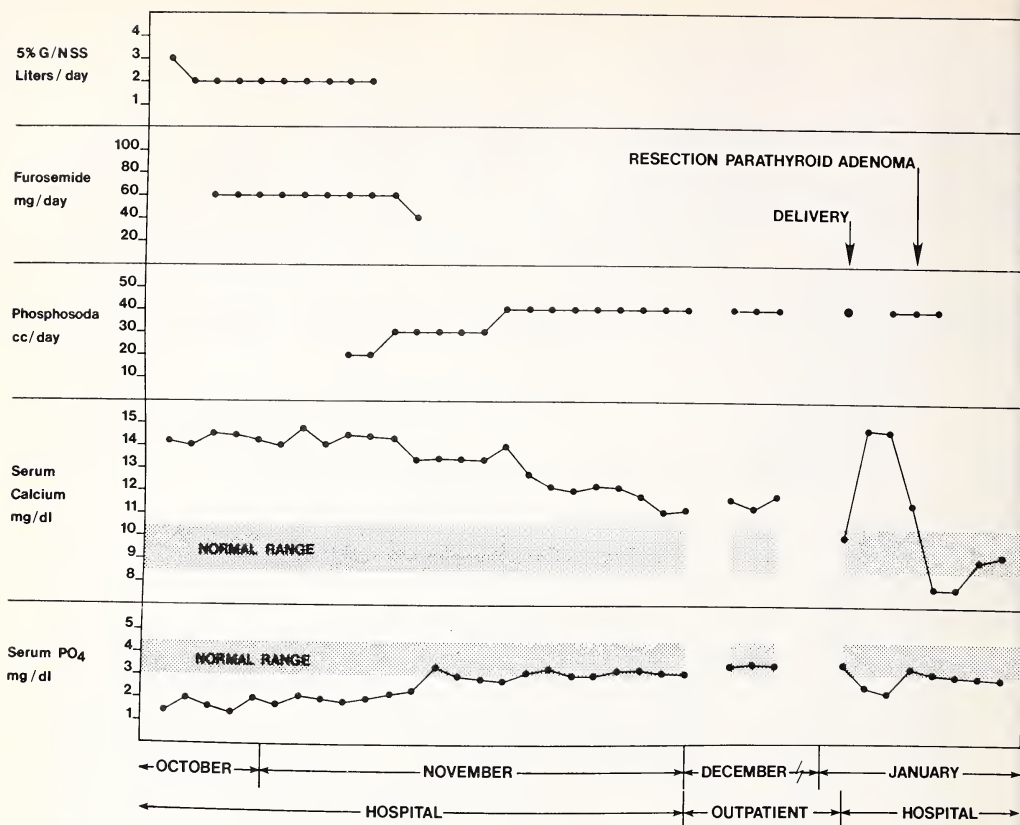
Parathormone assay was performed by the Upjohn Company (C fragment). It was reported as 741 picograms/ml with a calcium of 16.5 mg/dl, significantly above the normal range of 163-347 picograms/ml. This was considered strongly suggestive of hyperparathyroidism.

Chest x-ray revealed normal heart, lungs, mediastinum, and bony thorax. Films of the hands failed to demonstrate any evidence of fracture, dislocation or other osseous abnormality. A Panorex® examination of the mandible was normal except for the absence of lamina dura on several teeth.

The electrocardiogram showed a shortened QT suggestive of hypercalcemia.

Hemoglobin was 6.5 gm/dl, hematocrit 22.5 percent. The following laboratory studies were within normal limits: T₃, T₄, T₃, thyroid stimulating hormone, Coomb's test, serum iron, haptoglobins, blood sugar, urea nitrogen, cholesterol, serum albumin and globulins, lactic dehydrogenase, transaminase, electrolytes, and VDRL. The serum alkaline phosphatase was slightly elevated. During the first five hospital

*This study is from the Departments of Medicine, Surgery and Obstetrics, The Cooper Medical Center, Camden. Correspondence may be addressed to Dr. Levy at Cooper Medical Arts Bldg., 300 Broadway, Camden, NJ 08103.



days the serum calciums varied from 14.1 to a high of 14.9 mg/dl, the phosphorus from 1.2 to 1.9 mg/dl, and the serum chlorides from 107 to 110 mEq/l.

On reexamination of the neck one week after admission, a 0.5 x 1.0 cm. firm, non-tender nodule was palpated in the left upper portion of the thyroid; it was thought to represent a parathyroid adenoma. A surgical consultant recommended transfusion of packed red cells and excision of the tumor. The patient refused blood transfusions. Since no emergency appeared to exist, it was felt desirable to postpone surgery until her anemia was corrected by medical therapy. After the risks of hypercalcemia were discussed with the patient, medical therapy seemed indicated in an attempt to reduce her serum calcium. Initial treatment with three liters of 5 percent glucose in normal saline daily intravenously combined with 80 mEq. of oral furosemide twice daily briefly dropped her calcium to levels of 13.6 to 13.8 mg/dl. While this therapy was continuing, the serum calcium returned to previous levels above 14 mg/dl. Since there was no improvement, oral phosphosoda was started and increased from 30 ml. to 60 ml/day. This resulted in a decrease in serum calcium to 11 mg/dl (Figure 1). She was continued on this dosage throughout the remainder of the pregnancy. No diarrhea, abdominal pain, nausea or vomiting occurred during the therapy. During the antenatal course the hemoglobin increased from 6.9 to 11.3 gm/dl. The patient was delivered on 1/9/75 of a live female child weighing 8 lbs. 7 oz. The labor and delivery

were uncomplicated. The infant exhibited no tetany and continued to have an uneventful neonatal course. Phosphosoda therapy was resumed on the first postpartum day. Postpartum studies included a radioiodide thyroid scan, which showed a normal gland with a nodule external to the gland. A Selenium-Methionine SE 75 scan showed an area of uptake over the nodule 20 percent higher than the rest of the gland, a finding consistent with a parathyroid tumor. Her hemoglobin was 11.2 gms. percent, hematocrit 35 percent. A glucose tolerance test was borderline.

On 1/16/75 a tumor measuring 5.0 x 3.5 x 2.5 cm., weighing 28.5 grams, was removed. Microscopic sections revealed a benign parathyroid adenoma. Episodic hypocalcemia was controlled with intravenous calcium gluconate, but no other specific therapy was required during hospitalization. During the next three months the serum calcium and phosphorus remained within normal limits, and mother and child appeared well.

COMMENT

Goldsmith and Ingbar demonstrated successful therapy of hypercalcemia with oral phosphates.⁵ Massry *et al* showed that normocalcemia could be restored safely with oral or intravenous phosphates.⁶ The present case demonstrates that oral phosphate therapy during pregnancy can restore abnormally elevated calcium levels due to hyperparathyroidism to normal. This therapy produces minimal side effects and

"Oral phosphosoda during pregnancy is useful in controlling hypercalcemia until definitive treatment can be provided in the puerperium."

does not interfere with normal hemoglobin formation. Survey of the literature concerning phosphosoda therapy for hyperparathyroidism failed to reveal any cases treated during pregnancy. Oral phosphosoda during pregnancy is useful in controlling hypercalcemia until definitive treatment can be provided in the puerperium.

SUMMARY

Hypercalcemia due to the parathyroid adenoma was found

in the second trimester of an otherwise normal pregnancy. Refusal of surgical therapy led to treatment of hypercalcemia with oral phosphates. This well-tolerated medical program was successful in restoring normocalcemia throughout the remainder of the pregnancy, and a normal delivery without neonatal tetany resulted. Successful excision of the tumor was then carried out. An alternate medical program for hypercalcemia in pregnancy is suggested.

REFERENCES

1. Ludwig GD: Hyperparathyroidism in relation to pregnancy. *N Engl J Med* 267:637-642, 1962
2. Delmonico FL, Neer RM, Cosimi AB: Hyperparathyroidism during pregnancy. *Am J Surg* 131:328-337, March 1976
3. Gaeke RF, Kaplen EL, Lindheimer MD, et al: Maternal primary hyperparathyroidism of pregnancy: Successful treatment by parathyroidectomy. *JAMA* 238:508-509, August 1977
4. Johnson RE, Kreindler T, Johnson RE: Hyperparathyroidism during pregnancy. *Obstet Gynecol* 40:580, 1972
5. Goldsmith RD, Ingbar SH: Inorganic phosphate treatment of hypercalcemia of diverse etiologies. *N Engl J Med* 247:1, 1966
6. Massry SG, Mueller E, Silverman AG, Kleeman CR: Inorganic phosphate treatment of hypercalcemia. *Arch Intern Med* 121:307, 1968

Solitary Rectal Ulcer: Two Examples*

B.D. LIFSCHULTZ, M.D., F.A. CARONE, M.D.,
R. VRLA, M.D., Chicago

Two cases of the entity, solitary rectal ulcer, are reported. Each occurred in a severely ill and debilitated patient. One was especially unusual because fatal hemorrhage resulted when the ulcer eroded into a large serosal artery.

Solitary ulcer of the rectum first was recognized as an entity by Cruveilhier approximately 150 years ago.¹ Since then about 100 cases have been described including one series of 68 patients.² We report two additional cases. One is especially distinctive because the ulcer occurred in a patient with systemic lupus erythematosus (SLE) and resulted in fatal hemorrhage.

CASE REPORTS

Case 1—A 51-year-old male was admitted with dementia and incontinence of feces and urine. A diagnosis of SLE had been established six years earlier. The patient's mental status had markedly worsened during the several weeks prior to admission. Additionally, his sedimentation rate had risen from 30 to 80 one week previously. A computerized axial tomography (CT) brain scan performed six months prior to admission had shown enlarged ventricles consistent with cerebral atrophy. On admission, the patient was taking ten mg of prednisone daily. Additional past history was noncontributory.

The initial physical examination revealed a thin, middle-aged man with a plethoric complexion who was in no acute distress. He was afebrile and had a slightly rapid pulse. Auscultation of the chest revealed soft, bilateral basal rales. A fourth heart sound could be heard, but there were no murmurs. Neurologic examination revealed severe dementia, right-sided hyperreflexia and bilateral positive Babinski

signs. Additionally, there was a positive jaw jerk and clonus in both lower extremities. No anal sphincter tone was present; otherwise, the rectal examination was unremarkable with no blood detected in the stool.

The electrocardiogram and chest x-ray were unremarkable. Additional laboratory investigations revealed slightly elevated liver enzymes and a sedimentation rate of 30. A repeat CT scan of the brain was unchanged after six months. Radionucleotide brain scan was unremarkable.

Six days after admission, the patient developed bright red bleeding per rectum. Proctoscopy could not locate the source of hemorrhage, but the bleeding stopped within 24 hours. A lower GI x-ray series performed ten days after admission showed diverticulosis but no free barium in the peritoneal cavity. The patient began to run a low-grade fever but otherwise remained clinically stable for the next 24 hours. Suddenly, on the 11th hospital day, massive rectal bleeding developed. Despite attempts to locate the source of the hemorrhage and vigorous treatment with transfusions, the patient developed cardiac arrest and died within three hours.

At autopsy, a chronic ulcer measuring one and a half cm. in diameter and one cm. deep was found on the anterior wall of the rectum six cm. from the anus (Figure 1). This crater had eroded into a medium-sized serosal artery. On micro-

*From the Department of Pathology, Northwestern University Memorial Hospital, Jennings Pavilion, Third Floor, Superior Street and Fairbanks Court, Chicago, Illinois 60611. Dr. Lifschultz may be addressed there.

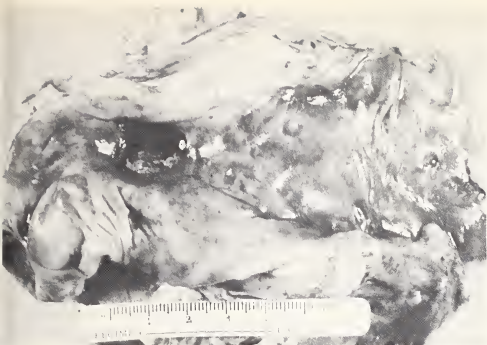


Figure 1—Gross photograph of ulcer measuring 1.5 cm. in diameter located in the rectum, 6 cm. from the anus.

scopic examination, there was much scarring around the ulcer with both acute and chronic inflammation present at the base. However, no evidence of vasculitis was found. Small, healed cerebral infarcts, less than one cm. in diameter, were seen in the left caudate nucleus and the left putamen. These appeared to extend into the internal capsule. On microscopic examination, there was severe sclerosis of the associated vessels. No evidence of cerebrovasculitis, however, was seen. Examination of sections from the kidneys revealed prominent mesangial thickening in many glomeruli consistent with lupus nephritis predominantly of the membranous type.

Case 2—A 76-year-old female was admitted with complaints of increasing pain at rest in her right foot. The patient had a history of peripheral vascular disease which had required the insertion of a left femoral peroneal artery bypass graft one year prior to admission. She also had angina pectoris. There was no past history of diabetes, hypertension or hyperlipidemia.

On physical examination, the patient was normotensive and afebrile but markedly emaciated. A left carotid bruit and bilateral pulmonary rales were noted. The right popliteal dorsalis pedis and posterior tibial pulses were decreased as were the left radial and brachial pulses. Femoral bruits were heard bilaterally.

Chest x-ray, electrocardiogram, hemogram, and blood chemical values were normal. Arterial flow studies showed markedly decreased pressures in the right popliteal, posterior tibial and dorsalis pedis arteries. The clinical impression was right-sided tibial peroneal trunk occlusion with severe protein-calorie malnutrition. A right-sided femoral anterior tibial bypass graft was inserted. The patient tolerated this procedure well, but one week after admission, she developed an acute myocardial infarction with arrhythmia. This was



Figure 2—Low-power photomicrograph of rectal ulcer showing ulceration of mucosa and erosion of the lesion through the muscularis. Note adjacent artery and thrombosed vein.

followed by hallucinations, confusion, and coma. Gangrene was noted in the left foot. Disseminated intravascular coagulation with decreased platelets, decreased procoagulants and increased fibrin split products developed. She died four days later of cardiorespiratory arrest.

Autopsy revealed an elderly emaciated white female with multiple surgical scars and incisions on both lower extremities. A large ecchymoses was noted over the right groin. There was wet gangrene of the left foot and ankle. A recent complete thrombotic occlusion of the left circumflex coronary artery was present with acute transmural infarct of the anterior lateral aspect of the left ventricle.

Examination of the gastrointestinal tract revealed a superficial ulcer on the anterior wall of the rectum; it measured three cm. in diameter and was three cm. from the anal verge. This ulcer did not appear to be a site of active bleeding. Microscopically, the rectal ulcer revealed fibrin and acute inflammatory cells with little scarring. Postmortem blood cultures grew *Streptococcus faecalis*. Examination of the brain was unremarkable.

DISCUSSION

Solitary ulcer of the rectum is seldom an aggressive disease. The lesion typically consists of a deep ulcer from one to three cm. in diameter usually in the anterior rectal wall. Chronic inflammation with fibrosis is seen at the base of such ulcers. Often there is a more superficial exudate composed predominantly of polymorphonuclear cells. No etiologic agent has yet been identified.⁴

Three cases of this entity have been described in which marked hemorrhage occurred. All of these patients were middle aged and seriously ill from other diseases. Associated symptoms were constipation, diarrhea and incontinence. All three patients were treated with diverting colostomies. One

“Solitary ulcer of the rectum . . . typically consists of a deep ulcer from one to three cm. in diameter, usually in the anterior rectal wall.”

“This entity . . . appears to be most severe in those persons of middle age who are severely debilitated. . . . It may result in critical or . . . lethal hemorrhage.”

died within a week of surgery from diabetic ketoacidosis. However, the other two patients recovered; one had undergone surgical removal of a meningioma and the other had suffered a cardiac arrest during bone marrow aspiration. Their colostomies were closed within one to two months and bleeding did not recur.²

Our first case may represent the only reported fatal hemorrhage resulting from solitary rectal ulcer. Like the other patients who suffered life-threatening rectal bleeding from their solitary ulcers, our patient was severely ill. He was in his early 50's with serious cerebrovascular disease and long-standing SLE. Our second patient was also severely ill and debilitated, however, her rectal ulcer differed in that, histologically, it appeared to have developed acutely. There was little scarring at the ulcer's base as there had been in the first case. Unlike the first case, severe bleeding from the solitary rectal ulcer was not a problem. Although the etiology of this entity remains obscure, it appears to be most severe in those persons of middle age who are markedly debilitated. In such patients, it may result in critical or even lethal hemorrhage.

SUMMARY

Two cases of solitary rectal ulcer are reported. This lesion typically appears as a wide, flat-based ulcer in the rectum of debilitated patients. No known cause has been determined for this entity. Our cases resemble other reports of solitary rectal ulcer in that the disease occurred in the severely ill. The first patient suffered from long-standing SLE while the second developed a consumptive coagulopathy after surgery. Especially significant in our first case is that the ulcer eroded into a large serosal artery and caused fatal hemorrhage. Though life-threatening bleeding has been known to result from solitary rectal ulcer, death is an unusual occurrence.

REFERENCES

1. Cruveilhier J: *Anatomie Pathologique du Corps Humain*. Paris, J.B. Bailliere, 1829. *Maladies du Rectum* 25:4, 1830.
2. Madigan MR, Morson BC: Solitary ulcer of the rectum. *Gut* 10:871-881, 1969.
3. Pejic R, Kuchler JA: Solitary ulcer of the rectum. *J Med Soc NJ* 74:46-48, 1977.
4. Delancy H, Hitch W: Solitary rectal ulcer: A cause of life-threatening hemorrhage. *Surg* 76:830-832, 1974.

Housing Application—Meadowlands Hilton Annual Meeting, MSNJ—May 15-19, 1981

Please Reserve: _____ Single _____ Double _____ Twin _____ Suite

Arrival: (date) _____ at (time) _____

Departure: (date) _____ at (time) _____

Name _____

Address _____

City _____ State _____ Zip Code _____

If double or twin name of person joining _____

Single: \$56

Twin: \$67

Double: \$67

Suite: \$150 and up

If range of rates is offered and rate requested is not available, the next available rate will be assigned. Reservations must be received no later than two (2) weeks prior to the opening date of your meeting and will be held until 6 p.m. on day of arrival unless otherwise specified.

(New Jersey Sales Tax - 5%)

Complete and mail this application to: Front Office Manager
The Meadowlands Hilton
Two Harmon Plaza
Secaucus, New Jersey 07094

Rhabdomyolysis with Acute Renal Failure in Legionnaire's Disease*

GARY GARTENBERG, M.D., MELVIN P. WEINSTEIN, M.D.,
NIRMAL K. FERNANDO, M.D., ROBERT DODELSON, M.D., New Brunswick,
SEYMOUR RIBOT, M.D., Newark

Rhabdomyolysis with acute renal failure developed in a patient with pneumonia, subsequently confirmed to be Legionnaire's disease. This infection should be added to the differential diagnosis of acute renal failure.

Although Legionnaire's disease is primarily a respiratory disorder, extrapulmonic manifestations are well recognized.^{1,2} To date the organism has been identified only in respiratory tissue and the pathophysiologic mechanisms of the extrapulmonic manifestations are unclear.³

Microscopic hematuria has been reported in ten percent of patients with Legionnaire's disease in one epidemic⁴, but serum creatinine abnormalities directly attributable to the disease are rare.³ Recently, an association of rhabdomyolysis and renal failure in Legionnaire's disease has been suggested.⁵ We report here a case of severe, oliguric, reversible renal failure in Legionnaire's disease, and conclude that rhabdomyolysis precipitated the renal disorder.

CASE HISTORY

A previously healthy 48-year-old woman was admitted to Middlesex General Hospital, New Brunswick because of pneumonia and mental confusion.

Three days prior to admission, the patient developed fever, dyspnea and weakness. Penicillin was administered. The patient became confused and incontinent of several diarrheal stools. She had no genitourinary symptoms, did not smoke cigarettes and did not drink alcohol.

At admission, the patient was lethargic but oriented. Temperature was 39.5°C, pulse 112, blood pressure 116/72 mm Hg, and respirations 32. Physical examination revealed signs of consolidation of the left lower lung field.

The urine had a specific gravity of 1.024 and gave a 4+ test for protein and a 3+ test for blood; pH was 6 and no glucose was present. The sediment contained 6 to 8 red blood cells and 0 to 2 white blood cells per high powered field; no casts were seen. The urine myoglobin was negative. Twenty-four hour urine volume was 380 ml with an osmolality of 528, sodium 7 meq/l, creatinine 0.8 gm/24 hr, and urea 170 mg/dl.

The hematocrit was 36.9 percent; the leukocyte count was 6500 with 77 percent neutrophils, 10 percent band forms, 3 percent myelocytes, 8 percent lymphocytes, and 2 percent monocytes. The erythrocyte sedimentation rate was 99 mm/hr (Westergren), blood urea nitrogen 52 mg/dl, serum creatinine 7.0 mg/dl and total bilirubin 1.0 mg/dl. The creatine phosphokinase (CPK) was 3300 U (normal 30-170 U), lactate dehydrogenase 880 U (normal 90-210 U), and the serum glutamic oxalacetic transferase 152 U (normal 8-30 U). CPK fractionation revealed 100 percent MM fraction.

An electrocardiogram showed sinus tachycardia and chest

*This report is from the Divisions of Infectious Disease (Drs. Gartenberg, Weinstein, Fernando) and Nephrology (Dr. Dodelson), Department of Medicine, CMDNJ-Rutgers Medical School and Middlesex General Hospital, New Brunswick, New Jersey and the Division of Nephrology (Dr. Ribot), Department of Medicine, Beth Israel Medical Center, Newark. Correspondence may be addressed to Gary Gartenberg, M.D., Division of Immunology and Infectious Diseases, Department of Medicine, CMDNJ-Rutgers Medical School, P.O. Box 101, Piscataway, New Jersey 08854.

roentgenogram revealed an infiltrate in the left lower lobe. A lumbar puncture revealed normal cerebrospinal fluid. Thirty milliliters of transudative fluid were obtained from a left thoracentesis. Ultrasound examination of the kidneys showed normal kidney size and a normal echo pattern for both the renal parenchyma and collecting system. Tc99m DTPA renal scan revealed diminished perfusion bilaterally.

Specimens of blood, cerebrospinal fluid, pleural fluid, urine and stool were sent to the laboratory for culture. Intravenous erythromycin was administered. Within four days the patient was afebrile, mentally lucid, and free of dyspnea. All cultures failed to reveal a pathogenic organism.

Oliguric renal failure persisted; the blood urea nitrogen rose to 102 mg/dl with a creatinine of 13.1 mg/dl. The CPK remained markedly elevated at 2680 U. Peritoneal dialysis was begun and the patient was transferred to Beth Israel Hospital, Newark for hemodialysis. Renal function gradually improved. The patient was discharged on the 28th hospital day with a blood urea nitrogen of 17 mg/dl and serum creatinine of 1.4 mg/dl.

One month later, the patient was asymptomatic and her physical examination was normal. Her urea nitrogen was 8 mg/dl and her creatinine was 0.8 mg/dl.

Indirect fluorescent antibody titers for *Legionella pneumophila*, as reported by the Center for Disease Control in Atlanta were as follows: day 3, < 1:32; day 17, 1:256; day 58, 1:512. Acute (day 3) and convalescent (day 58) sera showed no change in antibody titer for adenovirus, influenza A and B, and *Mycoplasma pneumoniae*.

DISCUSSION

A review of the Philadelphia epidemic of Legionnaire's disease reported severe renal failure in 14 of 123 patients.² However, 12 of these 14 patients had documented hypotension and shock, and there is no evidence to suggest rhabdomyolysis. In another report renal failure developed in a patient with Legionnaire's disease.⁶ The CPK was elevated but the renal biopsy showed acute idiopathic tubulointerstitial nephritis.

Friedman has reported acute renal failure in four patients with Legionnaire's disease.⁵ All had orthotolidin-positive urine, three had elevation of the CPK and one had pigmented casts in the urine sediment. Using previously established criteria, he suggested that myoglobinuria may have caused the renal failure.⁵

"Legionnaire's disease should be added to the differential diagnosis of acute renal failure, especially when associated with elevated CPK."

In the case we report, early involvement of the kidneys suggests that the renal failure was not a complication of hypoxemia, hypotension or antibiotic toxicity. The persistent and marked elevation of CPK, shown by isoenzymes to be of non-cardiac origin, and the orthotolidin-positive urine with only a few red cells in the sediment, strongly implicate non-traumatic rhabdomyolysis with myoglobinuria as the pathogenetic mechanism of renal failure. Further studies, perhaps including renal biopsy, should be considered to delineate this association.

CONCLUSION

Legionnaire's disease should be added to the differential diagnosis of acute renal failure, especially when associated with elevated CPK.

REFERENCES

1. Kirby BD, Snyder KM, Meyer RD, Finegold SM. Legionnaire's disease: Clinical features of 24 cases. *Ann Intern Med* 89:297-309, 1978.
2. Tsai TF, Finn DR, Plikaytis BD, McCauley W, Martin SM, Fraser DW. Legionnaire's disease: Clinical features of the epidemic in Philadelphia. *Ann Intern Med* 90:509-517, 1979.
3. Swartz MN. Clinical aspects of Legionnaire's disease. *Ann Intern Med* 90:492-495, 1979.
4. Fraser DW, Tsai TR, Orenstein W, et al.: Legionnaire's disease: description of an epidemic of pneumonia. *N Engl J Med* 297:1189-1197, 1977.
5. Friedman HM: Legionnaire's disease in non-Legionnaires: A report of five cases. *Ann Intern Med* 88:294-302, 1978.
6. Relman AS, McCluskey RT: Case records of the Massachusetts General Hospital: Acute renal failure and hemoptysis in a 44-year-old man. *N Engl J Med* 298:1014-1021, 1978.
7. Grossman RA, Hamilton RW, Morse BM, Penn AS, Goldberg M: Nontraumatic rhabdomyolysis and acute renal failure. *N Engl J Med* 291:808-811, 1974.

Pasteur

JOSEPH H. KLER, M.D., New Brunswick*

Sometimes pure science leads to unexpectedly important applications; conversely, the attempt of a gifted scientist to solve immediate and practical problems of industry may lead to the origination and development of theories of far greater practical value than the solution of the problem at hand. Nowhere has this truism been exemplified better than in the life of Louis Pasteur, who was trained as a chemist, employed by industry and by the French Government as an industrial trouble shooter, and elevated to his preeminence in science through his remarkable imagination and uncanny intuition. Theories interested him only when capable of translation into facts. His indomitable patience, persistence and industry led to his great achievements as the founder of modern microbiology, the father of the germ theory of disease, benefactor of mankind and one of the greatest names in science of all times.

Pasteur was the most striking figure in 19th century science, in biology, chemistry, physics, medicine and surgery, and in the important practical subjects of fermentation and spontaneous generation. In sanitation, he left landmarks that represented great advances in science and starting points for new explorations into the as yet unmapped domain of scientific knowledge. His was a typically scientific mind. His intuitions were marvelous in their prophetic accuracy and yet they were surpassed by his wonderful faculty for evolving methods of experimental demonstration of his theories. His work changed the whole aspect of biology and medicine, and especially the branches of it that refer to prevention.

A catalog of Pasteur's work displayed in the Pasteur Institute in Paris records the following:

- 1849 Molecular dissymmetry (Crystallography)
- 1857 Fermentation
- 1862 So-called spontaneous generation
- 1863 Studies in wine (Pasteurization of wine, milk)
- 1864 Diseases of silk worms (two)
- 1871 Studies in beer
- 1877 Virulent microbial diseases
- 1880 Vaccinating viruses
- 1885 Prophylaxis of rabies

MUSCULAR DISSYMMETRY

These subjects seem widely separated but each successive subject follows the predecessor at rigid logic. A study of Pasteur's work in each case shows the advances made in each one. Pasteur was first and always a chemist—it was his first interest. In the decade from 1840 to 1850 he was primarily

interested in the internal constitution of molecules and the arrangement of atoms in substance which, though composed of exactly the same constituents, exhibited different physical and chemical qualities. This led to his interest in and studies of the crystals of paratartrates and he was the first to discover dissymmetry in these crystals. It was characteristic of Pasteur through his life to have no doubt of the true significance of his work, having been meticulously careful in proving to himself the accuracy of his tests of proof. Whenever he conceived an idea he immediately thought out the experimental demonstration. This made him feel certain that each step in the demonstration and his conclusions were beyond doubt. He discovered the great fundamental distinction between organic and inorganic substances—all organic substances have dissymmetry while the inorganic do not. He thus created the new science of stereochemistry—the study of physiochemical arrangement of atoms within molecules.

Pasteur was fascinated by the concept that dissymmetry forces were the causes of many of the natural phenomena that could be observed in the universe. He tried to induce dissymmetry in crystals by making them grow in magnetic fields. He tried to grow plants under light that had been "reversed" by the use of mirrors, and he studied the growth of plants subjected to artificial magnetic fields. But in these experiments he found nothing of fertile nature and time did not permit return to these studies.

LOVE, ACADEMIC ACHIEVEMENT AND FERMENTATION

In January, 1849, Pasteur was appointed professor of chemistry at the University of Strasbourg. Here he fell in love with Marie, one of the daughters of M. Laurent, the Rector of the University and they were married in May. Pasteur wrote to his college roommate and close friend: "I believe that I shall be very happy. Every quality I could wish for in a wife, I find in her. You will say, 'He is in love!' Yes, but I do not think I exaggerate at all!" Time proved that Pasteur

*Dr. Kler is a New Brunswick ophthalmologist/otolaryngologist and student of medical history. He was the leader in the restoration (in Piscataway near Rutgers Medical School) of "East Jersey Olde Towne," a typical colonial village of the 18th century which includes the office of Dr. Henry Vander Veer, nephew of Lawrence Vander Veer, one of the founders of MSNJ. Dr. Kler is Chairman of the Board of Trustees of the NJ Commission for the Blind and Visually Impaired and a member of the recently established Medical History Society of New Jersey. Correspondence may be addressed to him at PO Box 431, New Brunswick, NJ 08903.

did not exaggerate. Mme. Pasteur shared with her husband all his joys, his sorrows and his hopes, his whole life long.

In September 1854, he was made professor and dean of the faculty of science in Lille. Here he began the work that carried his name to the four corners of the world. Lille was a great industrial and agricultural center and it was this fact that started Pasteur on his studies of fermentation. Fermentation is as old as the world; people had made use of it from the time they learned to bake bread and to make wine and beer. Thus, in the 19th century, all they knew about it was that sugar in a fermentable substance, like crushed grapes or crushed barley sprouts, was changed into alcohol and carbonic acid by some mysterious process. In 1835, two scientists, Schwann in Germany and Latour in France, performed independent microscopic studies of the yeast used in the making of beer. Schwann discovered that fermentation takes place in sugar and water only when yeast is present. In 1854, Pasteur began to study fermentation and started his own fermentation to help a Lille manufacturer who had been having trouble in making beet-root alcohol. Pasteur widened his field of study of fermentation by studying the souring of milk. Thus, by chance, Pasteur's interest in crystals was turned to the investigation of fermentation. In his inaugural address at Lille, he said, "In the fields of observation, chance favors only the prepared minds."

He then proceeded to prove the truth of his oft-quoted dictum. He studied alcoholic fermentation and lactic fermentation in milk. In alcoholic fermentation, he saw round globules when the fermentation was healthy and long threads when lactic acid appeared. In 1857, he stated that the change of sugar into alcohol and carbonic acid is correlative to a phenomenon of life, an organization of globules—"fermentation is caused by minute organisms and that when it does not occur, these minute organisms either have not been introduced or find it impossible to live."

SPONTANEOUS GENERATION, "PASTEURIZATION"

These investigations of Pasteur revived an old controversy concerning spontaneous generation. His demonstrations that both alcoholic and lactic fermentation were produced by minute organisms and were hastened by exposure to the air, brought up the question of whether they were always present in the air or whether they were spontaneously generated in the solutions. Pasteur devised his ingenious "goose-neck" flask to demonstrate the proof of his findings and statements. This well-known experiment showed that an infusion, when boiled in a flask which is left open, will putrefy, whereas, when it is boiled in his goose-neck flask it will remain pure because the air will "drop its dust and germs" at the opening of the neck of the first curve. This was the crucial experiment that suggested antiseptics to Lister.

In 1864, Pasteur was asked by the government to study a disease which was ruining the wine industry of Jura by making the wine sour and unpalatable. He found the wines were spoiled by parasitic growths and that these could be destroyed by heating the wine for a few moments at a temperature of 50 to 60 degrees C. This process which was extended to milk and to other fields has perpetuated his name through the term, "pasteurization." Pasteurization of milk has saved the lives of untold millions of babies.

The studies on fermentation led Pasteur to the discovery of strict anaerobiosis. The order and harmony that pervade Pasteur's scientific work often have been pointed out. However diverse, the subjects he dealt with always were related one to the other.

DISEASES OF SILKWORMS AND STUDIES OF BEER

Since 1849, a disease had ravaged the silkworm nurseries in southern France. The cocoon output fell from the record high of 26 million kilograms in 1853 to four million. The egg, the worm, the chrysalis, the moth, all were attacked. One of the signs of the disease was the appearance of little black or brown spots on the sick worms. Because these spots looked like pepper grains, the disease was called *pébrine*, after the word *pebre* (pepper). All sorts of remedies were tried without success. The disease spread from France to Spain, Italy, Greece, Syria, Provinces of the Caucasus and to China. In 1865 the famous chemist Dumas, a friend of Pasteur, then a senator, asked Pasteur's help. Reluctantly Pasteur agreed and went to Alais where his work was to start. As was the case with wines, there was more than one disease, *pébrine* and *flacherie* of silkworms, and five years passed by before Pasteur published a practical solution suitable for use by growers. Strangely, the growers were reluctant to accept Pasteur's solution of their problem. It was necessary for Pasteur actually to demonstrate the effectiveness of his program in the vineyard of French Prince Imperial where he turned an annual financial deficit to an annual profit of 20,000,000 francs.

In 1867, Pasteur left the *École Normale* and the next year France provided a laboratory for him where he could carry out further researches he had planned. In 1869, he suffered a paralysis of the left side and there seemed little hope of his recovering. Fortunately six months later he was back in Alais working with the silkworms. In 1874, Pasteur was voted a grant of 12,000 francs a year for the rest of his life by the National Assembly, in recognition of his services to France and humanity, Pasteur was always cordial to all scientists but he was extremely friendly with young student scientists. In Pasteur's life we see beautifully blended the veneration of the student for his teacher and the love of the teacher for his students.

By this time Pasteur was more a microbiologist than a chemist. During this period France suffered a crushing defeat in the Franco-Prussian War and this developed a strong germanophobia in Pasteur due to his strong love of his country. This germanophobia gave Pasteur impetus to study the manufacture of beer. He wanted French beers to emulate and to surpass the preferred German beers. Whether he succeeded or failed in this patriotic endeavor is purely a matter of one's personal taste. He studied the manufacture of beer in a number of French breweries and then went to London, where he investigated the large British establishments. He then stated, "Every marked alteration in the quality of beer coincides with the development of micro-organisms foreign to the nature of true beer yeast." Pasteur showed that this could be prevented, as in the case of wines, by heating the beer to a temperature of 50 to 60 degrees C. This pasteurized beer was much superior to the previous beer.

With the studies on beer a chapter in the scientific work of Pasteur came to a close.

CONTAGIOUS DISEASES

Pasteur had concluded his work in the field of industrial microbiology; he had introduced the laboratory into the factory and the microscope to the farm (this has reference to the silkworm diseases where the eggs of the moth are examined under the microscope.). From then on he was to apply his talent to the study of contagious diseases of

vertebrates with brilliant results for the benefit of animals and man.

In 1877, after having revolutionized the manufacture of wine, vinegar and beer and after having firmly established the germ theory of disease and saved the silk industry of France, Pasteur turned his attention to anthrax, or splenic fever, a disease which was decimating the flocks of sheep and sometimes cattle and even affected man. During these studies his work was interrupted by studies on chicken cholera that had appeared in an epidemic form and was destroying a very large number of fowl. He soon isolated the specific causative microbe. When fresh cultures of this microbe were inoculated into healthy chickens they were lethal while old cultures not only lost their virulence but when injected into chickens protected them from a second inoculation with a fresh and virulent culture. Here again Pasteur's mind took advantage of this observation and he developed an effective method of "vaccinating" chickens to make them immune to the development of chicken cholera. Thus he discovered another basic principle, i.e., the development of immunity through vaccination with attenuated culture of the causative bacteria.

Pasteur then returned to the study of anthrax and, employing similar methods, announced two years later that animals injected with a culture of anthrax bacillus, attenuated by growing the organism at 42 degrees C., were protected from the fatal results of later injection of a virulent culture. The announcement was greeted with skepticism by many Frenchmen and the editor of the *Veterinary Press* challenged Pasteur to a public trial of his anthrax vaccine. Pasteur accepted this challenge. The Melun Agricultural Society placed 50 sheep at Pasteur's disposal. The news of the proposed experiment attracted much publicity and attention. A large crowd of physicians, veterinarians, journalists and farmers gathered at Melun on May 31, 1881 to witness Pasteur's crucial experiment. Twenty-five sheep which had previously been vaccinated with Pasteur's attenuated cultures of the anthrax bacillus and twenty-five unvaccinated sheep and one cow were injected with virulent anthrax cultures. Two days later, before the same crowd of spectators, all the vaccinated sheep were alive and well and all the unvaccinated sheep and the cow were dead. The experiment was a spectacular success; "the whole of France burst out into an explosion of enthusiasm" (Vallery Radot, Pasteur's grandson). Pasteur christened his method "vaccination" in honor of Jenner for his successful vaccination of human beings with cowpox material to protect against smallpox.

While still working on the problem of anthrax, Pasteur began another series of experiments which led to the most startling and dramatic discovery of his entire career. Pasteur began his studies on rabies in 1880 when a veterinary surgeon brought to his laboratory two dogs suffering from rabies.

His first experiments were with the transmission of the disease. It was well known that rabies was transmitted by the saliva of a rabid dog, but Pasteur, who was convinced from the appearance of the animals that the virus must be present also in the nervous system, inoculated healthy dogs with bits of the medulla oblongata from a rabid animal and found that the dogs soon developed rabies. "Since this unknown being is living," thought Pasteur, "we must cultivate it; failing an artificial medium, let us try the brain of living rabbits." As soon as a rabbit died of rabies, a bit of the medulla was removed and inoculated directly into the brain of a healthy rabbit, and the process repeated when the inoculated rabbit succumbed. Inoculation succeeded inoculation and the peri-

od of incubation was steadily reduced until, after 100 successive inoculations, it was reduced to seven days. Inoculations past this point produced no reduction in the incubation period, which remained fixed at seven days. This virus was subsequently referred to as the fixed virus. Pasteur could now predict the day of death in an inoculated animal.

After having learned how to increase the virulence of the virus, he then sought to attenuate its virulence, as he had done in chicken cholera and anthrax. After numerous experiments, he found that a bit of rabid medulla, after having been desiccated for 14 days, lost its virulence. He then performed the experiment of inoculating dogs the first day with bits of medulla which had been dried for 14 days, the next day a 13 day fragment, continuing this process until in the 15th day the dog received a bit of fresh rabid material and did not develop the disease.

Pasteur continued these experiments and demonstrated before a commission appointed by the Minister of Public Instruction that his method could protect healthy dogs from the bite of a rabid animal. However, he had not had an opportunity to test his method on a human being until July 6, 1885 when Joseph Meister, a nine-year old Alsatian boy was brought to Pasteur's laboratory by his mother. Mrs. Meister described how her son had been bitten by a rabid dog two days previously.

Pasteur's emotions were deeply stirred at the sight of the boy, who had lost 14 pounds and was so weak he could scarcely stand. He was hesitant to employ his method on the little patient so he first consulted Dr. Vulpian and Dr. Grancher. When they urged him to apply the antirabic vaccination, the boy was immediately injected with material from a 14-day desiccated rabid cord. The injections were continued daily while Pasteur went through a succession of hopes, fears and anguish. His mental agitation was such that he could not work or even sleep. On July 16, he inoculated the boy with some material which was only one day old and which would surely produce hydrophobia in rabbits after only seven days' incubation. The boy continued to be well; the treatment was a success. Pasteur, worn out by the long vigil, retired to the country to rest. On August 3, he wrote to his son, "Very good news last night of the bitten lad . . . It will be 31 days tomorrow since he was bitten." On October 26, Pasteur described the treatment of Joseph Meister before the Académie des Sciences and added that three months and three days had passed and the child remained perfectly well. Soon patients who had been bitten by rabid dogs came from far and wide to receive the treatment. Four Newark children, who were the first Americans to receive this treatment, were sent to Paris in December 1885.

HONORS AND INTERNATIONAL RECOGNITION

The news of Pasteur's successful treatment spread like wild-fire. The Académie des Sciences recommended that an establishment be founded in Paris for the prevention of rabies and that it be called the Institute Pasteur. A wave of enthusiasm and generosity spread from one end of France to the other and to other countries. Presently, the sum of 2,500,000 francs had been raised for this purpose. The list of contributors contained such notable personages as the Czar of Russia, the Emperor of Brazil, and the Sultan of Turkey. The completed buildings of the Pasteur Institute were dedicated at a simple ceremony in 1888. Ill and weary at this time, Pasteur himself never was able to take up active work in the new laboratories.

As an official delegate of France to the tercentennial

celebration of the University of Edinburgh in 1884, Pasteur was signally honored when his name was called and as he walked toward the speaker's platform his appearance was greeted with a perfect outburst of applause; five thousand men rose and cheered him. It was an extremely splendid ovation.

The next morning, at ten o'clock, crowds gathered on the railroad station platform and waved handkerchiefs to bid Pasteur goodbye. The people were showing each other an Edinburgh daily paper, in which Pasteur's speech was reproduced.

France and the world celebrated Pasteur's seventieth birthday. On the morning of December 27, 1892, the great theatre of the Sorbonne was filled. The seats of honor held the French and foreign delegates from scientific societies, the members of the Pasteur Institute, and the professors of faculties. In the amphitheater were the deputations from the École Normale, Polytechnique, Centrale of Pharmacy, Veterinaires, and of Agriculture. The first gallery was full of those who had subscribed toward the presentation about to be made to Pasteur. In the second gallery, boys from the lycées crowned the assembly with a youthful garland.

At half past 10 o'clock, while the band of the Republican Guard played a triumphal march, Pasteur entered, leaning on the arm of the President of the Republic. President Garnot led Pasteur to a little table, whereon the addresses of the various delegates were to be laid. The Presidents of the Senate and of the Chamber, the Ministers and Ambassadors, took their seats on the platform. Behind the President of the Republic stood the official delegates in the uniforms of the five Académies which form the Institute de France. The Academy of Medicine and the great scientific societies were represented by their presidents and life secretaries.

M. Charles Dupuy, Minister of Public Instruction, after retracing Pasteur's great works said, "Who can now say how much human life owes you and how much more it will owe to you in the future! . . . May France keep you for many years, and show you to the world as the worthy object of her love, of her gratitude and pride."

The great Lord Lister, who represented the Royal Societies of London and Edinburgh, brought to Pasteur the homage of medicine and surgery. "You have," said he, "raised the veil which had covered infectious diseases, you have discovered and demonstrated their microbial nature." When Pasteur rose to embrace Lister, the sight of those two men gave the impression of science working to diminish the sorrows of humanity. Lister and Pasteur collaborated with each other without any feeling of rivalry. All of the delegates presented their addresses. Every large city of Europe had its representatives. The last word of homage was pronounced by M. Davise, President of the Students' Association, who said "you have been very great and very good; you have given a

beautiful example to students."

Pasteur's thanks were read by his son—"Monsieur le President de la Republique, your presence transforms an intimate fete into a great ceremony, and makes of the simple birthday of a savant a special date for French science . . . And you delegates from foreign nations, who have come from so far to give to France a proof of sympathy, you bring me the deepest joy that can be felt by a man whose invincible belief is that science and peace will triumph over ignorance and war, that nations will unite, not to destroy, but to build and that the future will belong to those who will have done most for suffering humanity. I appeal to you, my dear Lister and to you all, illustrious representatives of medicine and surgery . . . Young men, young men, devote yourselves to those sure and powerful methods, of which we as yet know only the first secrets. And I say to all of you, whatever may be your career, never permit yourselves to be overcome by degrading and unfruitful scepticism . . . so that some day that supreme happiness may come to you, the consciousness of having contributed in some manner to the progress and welfare of humanity."

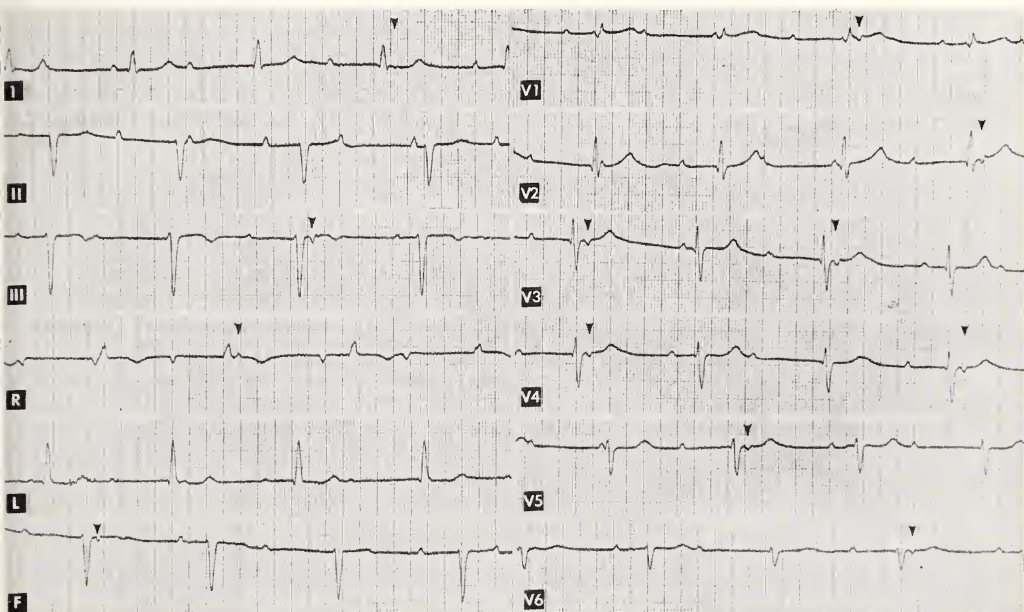
Perhaps more than any other man of genius, Pasteur was to combine great scientific ability with a constant concern for human happiness. For him, science was no abstract pursuit of cold truth, but a living, loving form of service. His contribution to our well-being is immense.

During his lifetime, Pasteur received all the honors that France could bestow; membership in the Académie des Sciences (1862), the Académie de Médecine (1873), the Grand Cross of the Legion of Honor (1880). During his Paris period, he was successively director of scientific studies at the École Normale (1857-1863), professor of geology and chemistry at the École des Beaux-Arts (1863-1867), professor of chemistry at the Sorbonne (1867-1889) and director of the Institute Pasteur. Most of his great discoveries were first described at either the Académie des Sciences or the Académie de Médecine and published in their transactions. Four important monographs appeared during his lifetime: *Études sur le Vin*, 1866; *Études sur le Vinaigre*, 1868; *Études sur la Maladie des Vers à Soie*, 1870; and *Études sur la Bière*, 1876.

Pasteur was a devout Catholic but, as a scientist, he claimed absolute liberty of research. "Science," he said, "should not concern itself in any way with the philosophical consequences of its discoveries." He considered it a waste of time to seek an explanation for primary causes or the mystery of the universe. He believed that the domain of religion and science, "are distinct, and woe to him who tries to let them trespass on each other in the so imperfect state of human knowledge." On September 28th 1895, Pasteur died quietly, one hand clasping a crucifix, the other the hand of his wife.

Retrograde Ventriculo-Atrial Conduction in Complete Antegrade Atrioventricular Block: An Electrocardiographic Demonstration

SHASHI K. AGARWAL, M.D., Albuquerque, NM*



The electrocardiogram was recorded from an 86-year-old, male admitted to Bergen Pines County Hospital with dizziness and syncope. There was a previous history of a myocardial infarction. Treatment included implantation of a permanent transvenous endocardial demand pacemaker.

INTERPRETATION OF THE ELECTROCARDIOGRAM

The electrocardiogram shows complete atrioventricular block. The sinus rhythm is regular at a rate of 66 per minute and exhibits no forward relationship to the ventricular activity. The ventricular complexes are wide (QRS duration 0.14 seconds) and occur at a regular rate of 41 per minute. Their configuration is of the complete right bundle branch block and left anterior fascicular block type with suggestion of an anteroseptal wall myocardial infarction of indeterminate age. Interestingly, ventricular beats occurring late after an atrial depolarization demonstrate retrograde conduction in the atria (arrowheads) as evidenced by

(1) negative P waves in leads III, AVF, V1 to V6, (2) presence of the phenomenon only following atrial recovery, (3) constant R-P interval. These atrial depolarizations reset the sinus node and thereby modulate sinus node activity.

DISCUSSION

Although complete heart block implies absolute independence of the atrial and ventricular pacemakers, interplay between the two often is observed. Ventricular contraction may influence sino-atrial activity by modulating intra-atrial pressure,¹ sinus node blood flow,² or systemic blood pressure.³ Mechanical traction on the atria⁴ or transmission of subthreshold electrical impulses⁵ as a result of idio-ven-

*When this report was prepared, Dr. Agarwal was a Fellow in Cardiology at St. Michael's Medical Center in Newark. He may be addressed now at the University of New Mexico Hospital, 2211 Lomas Blvd., NE, Albuquerque, NM 87106.

tricular depolarizations also may lead to such ventriculo-atrial inter-effect. Infrequently, a fortuitous rate relationship between the two rhythms may simulate actual synchronization.

Rarely, the ventricular impulses may conduct retrograde to the atria and have a more direct effect on sinus function. In 1929, Wolferth and McMillan suspected retrograde ventriculo-atrial conduction in complete orthodromic atrioventricular block.⁶ Since then several investigators have confirmed this phenomenon Winternitz and Langendorf, in 1944, collected 19 cases of unidirectional block from the literature and described six of their own.⁷ In 1964, Scherf and Cohen reviewed 84 such cases previously reported and added three of their own.⁸ In 1974 Cohen and associates performed His Bundle electrocardiography on patients with complete heart block and recognized the entity of concealed retrograde conduction.⁹ More recently, Khalilullah and colleagues studied 42 patients with atrioventricular block and demonstrated intact ventriculo-atrial conduction in 22, thereby suggesting a higher incidence than previously accepted.¹⁰

Although numerous theories have been postulated to explain this phenomenon of sequential ventriculo-atrial depolarization in complete orthograde atrioventricular block,¹¹⁻¹⁵ the majority of patients appear to have actual ventriculo-atrial conduction via the AV node,¹⁰ by mechanisms still unexplicable. Its recognition has benign implications in the setting of complete heart block as hemodynamic alterations do not occur. Its significance is limited to its being an electrophysiological curiosity.

CONCLUSION

The occurrence of retrograde ventriculo-atrial conduction in the presence of complete antero-grade atrioventricular transmission block is an uncommonly encountered but well substantiated electrocardiographic entity. Recent electrophysiological studies have suggested that its incidence is much higher than generally realized, many cases being missed on the surface electrocardiogram due to the phenomenon of concealed conduction. This report presents

an illustrative electrocardiogram and briefly reviews its characteristics.

REFERENCES

1. Schroeder W, Brehm H: Untersuchungen über den adäquaten Reiz des Bainbridge-Reflexes. *Arch ges Physiol* 255:114-129, 1952.
2. Watanabe Y, Dreifus LS: Newer concepts in the genesis of cardiac arrhythmias. *Am Heart J* 76:114-135, 1968.
3. Levy MN, Edelstein J: The mechanism of synchronization in isorhythmic AV dissociation. II. Clinical studies. *Circulation* 42:689-699, 1970.
4. Rosenbaum MB, Lepeschkin E: The effect of ventricular systole on auricular rhythm in auriculo-ventricular block. *Circulation* 11:240-261, 1955.
5. Sideris DA, Anthopoulos LP, Mouloupoulos SD: Ventriculophasic arrhythmia and synchronization: Clinical observations and study on an electrical analogue. *J Electrocardiol* 11:239-246, 1978.
6. Wolferth CC, McMillan MT: Observations on the mechanism of relatively short intervals in ventriculoauricular and auriculoventricular sequential beats during high grade heart block. *Am Heart J* 4:521-544, 1929.
7. Winternitz M, Langendorf R: Auriculo-ventricular block with ventriculoauricular response. Report of six cases and critical review of the literature. *Am Heart J* 27:301-321, 1944.
8. Scherf D, Cohen J: *The Atrioventricular Node and Selected Arrhythmias*. New York, Grune and Stratton, 1964, pp. 208-225.
9. Cohen SI, Smith LK, Aroesty JM, et al: Concealed retrograde conduction in complete atrioventricular block. *Circulation* 50:496-498, 1974.
10. Khalilullah M, Singhal N, Gupta U, et al: Unidirectional complete heart block. *Am Heart J* 97:608-612, 1979.
11. Cohn AE, Fraser FR: The occurrence of auricular contractions in a case of incomplete and complete heart block due to stimuli received from the contracting ventricles. *Heart* 5:141-156, 1914.
12. Scherf D: Retrograde conduction in complete heart block. *Dis Chest* 35:320-327, 1959.
13. Wu D, Cummings J, Denes P, et al: Complete atrioventricular block with intact retrograde conduction due to a concealed extranodal anomalous pathway. *Chest* 71: 762-764, 1977.
14. Kline EM, Conn JW, Rosenbaum FF: Variations in A-V and V-A conduction dependent upon the time relations of auricular and ventricular systole: The supernormal phase. *Am Heart J* 17: 524-535, 1939.
15. Gupta PK, Haft JJ: Retrograde ventriculoatrial conduction in complete heart block: Studies with His Bundle electrography. *Am J Cardiol* 30: 408-411, 1972.

215th Annual Meeting Medical Society of New Jersey May 15-19, 1981

Housing Application The Meadowlands Hilton

Please Reserve: _____ Single _____ Double _____ Twin _____ Suite _____

Arrival: (date) _____ at (time) _____

Departure: (date) _____ at (time) _____

Name _____

Address _____

City _____ State _____ Zip Code _____

If double or twin name of person joining _____

Single: \$56

Twin: \$67

Double: \$67

Suite: \$150 and up

If range of rates is offered and rate requested is not available, the next available rate will be assigned. Reservations must be received no later than two (2) weeks prior to the opening date of your meeting and will be held until 6 p.m. on day of arrival unless otherwise specified.

(New Jersey Sales Tax - 5%)

Complete and mail this application to: Front Office Manager
The Meadowlands Hilton
Two Harmon Plaza
Secaucus, New Jersey 07094

Women and Nutrition*

LILLA AFTERGOOD, Ph.D. and

R. B. ALFIN-SLATER, Ph.D., Los Angeles, CA

The extent to which dietary requirements of women differ from those of men only recently has been recognized. The importance of a well-balanced diet for pregnant and lactating women has been understood since early studies attempted to correlate nutrition with health. Scientific research now confirms the increase in certain nutrient requirements during other physiologically demanding times as well as during pregnancy and lactation.

CHILDHOOD AND ADOLESCENCE

Prior to adolescence, there is little difference in yearly height increments between the sexes. As a result, differences in nutritional requirements for males and females have not been established for children under 11 years of age.¹ During adolescence, however, there are very distinct changes in body composition, and separate requirements have been established for 11 to 14-year-old males and females. However, the growth rates of individuals vary as well as the time period in which this growth occurs; therefore, it is difficult to predict when an individual child will have specific nutrient requirements.

NUTRITIONAL ANEMIAS

From adolescence to menopause, females are more susceptible than males to various nutritional anemias. These anemias are generally related to a dietary deficiency of, or an increased need for, iron, folic acid (folate, folacin) or vitamin B₁₂.²

It has been observed that approximately 40 percent of women aged 20 to 50 show indications of iron inadequacy.³ According to the Recommended Dietary Allowances (RDA), the estimated iron requirement of menstruating women is 18 mg/day. It is difficult for women and teenage girls to obtain sufficient amounts of iron from an average diet since the average American diet provides only about 6 mg of iron per 1000 Kcal and the average calorie intake for women is about 1550 calories.⁴ Therefore, women are obtaining about 9 mg of iron from their food—or half the daily requirement. In addition, the absorbability of iron from different food sources is highly variable. Heme iron from meat, fish and poultry is about 35 percent absorbed. On the average, however, only about 10 percent of the amount of iron consumed actually is absorbed. Vitamin C eaten with iron-containing food promotes iron absorption.

Folic acid deficiency is prevalent among females who do not ingest adequate amounts of green, leafy vegetables or some fruits. Long-term folic acid deficiency results in megaloblastic anemia which interferes with cell duplication and, therefore, growth.

MENSTRUAL "DEPRESSION"

Menstrual "depression" (similar to that occurring in some women using oral contraceptives) has been treated successfully on occasion with increased amounts (10 mg) of vitamin B₆. The reason for this condition apparently is the effect of estrogen on the action of vitamin B₆ on tryptophan metabolism, which in turn affects neurotransmitter metabolism.⁵

ORAL CONTRACEPTIVES

In the last few decades a new nutritional hazard for women has surfaced; namely, the influence of oral contraceptives. The extent of this effect depends on several factors: the composition of the oral contraceptive used, the age of the woman, the length of time of exposure to the "Pill," and the nutritional status of the individual prior to the administration of the oral contraceptive. If a "borderline" deficiency of a specific nutrient exists, it is usually exacerbated by the introduction of the "Pill."⁶

However, since women taking oral contraceptives tend to have a reduced menstrual blood loss, and possibly an elevated iron-binding capacity, their requirement for iron is lower. A controversy still exists as to the effects of oral contraceptives on the metabolism of some other minerals, particularly calcium.

Since plasma vitamin A levels have been found to increase in oral contraceptive users, a decreased requirement for vitamin A has been suggested by some researchers.⁷ Some animal studies indicate that this may be the result of an accelerated release of vitamin A from the liver.⁸

On the other hand, a deficiency of nutrients such as vitamin B₆ and folic acid actually may develop as a result of oral contraceptive use. A borderline deficiency of folic acid is often found in young women due to inadequate diets and can be exacerbated by oral contraceptives or by pregnancy. A daily supplement of 100µg folic acid has been recommended for women using oral contraceptives to prevent the characteristic megaloblastic anemia which may result from a deficiency. An impairment of vitamin B₆ metabolism also has been observed as reflected by its reduced serum levels, changes in tryptophan metabolism, and by "depression" due to serotonin insufficiency. However, many women do not exhibit these changes.⁹ Daily supplements of 5 to 10 mg

*Reprinted with Permission of Contemporary Nutrition 5:3 (March) 1980, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Drs. Aftergood and Alfin-Slater are on the faculty of the School of Public Health, University of California, Los Angeles, CA.

vitamin B₆ have been suggested.

The metabolism of vitamin C is characteristically different in women than in men. Higher serum levels of vitamin C are reported in women during the high estrogen and luteinizing hormone (LH) secretion phases of the menstrual cycle. Oral contraceptive intake prevents these typical fluctuations of serum vitamin C content, possibly reflecting alterations in tissue distribution of this vitamin.¹⁰ These changes are physiological rather than pathological.

Thiamin, riboflavin and vitamin B₁₂ levels in the blood also have been shown to be decreased by the administration of oral contraceptives but to a lesser extent. While the effects of the "Pill" on vitamin E status are still controversial, no supplementation of vitamin E has been suggested, however.

In general, it is considered that a well-balanced diet (four food groups) eaten regularly will assure the nutritional well-being of women taking oral contraceptives. A low-level vitamin supplement, maintenance rather than therapeutic, which contains amounts closely adhering to the RDA, may be advisable in cases where the diet is suspected to be borderline or inadequate.

PREGNANCY

Pregnancy is a significant physiological development with potentially serious nutritional ramifications. An inadequate diet may affect fetal development as well as the nutritional well-being of the mother. This is of particular importance in cases of teenage pregnancy.

The maternal weight gain is usually an indication of birthweight and/or fetal development. It has been calculated that the total energy cost of pregnancy amounts to approximately 75,000 Kcal, which in turn represents a daily increment of 300 Kcal or an additional requirement of 15 percent over the RDA.¹ Both underweight and obese pregnant women face certain hazards. The increased risk imposed by obesity suggests a restriction of weight gain at this time; however, dietary restrictions during pregnancy are not recommended as they may decrease the necessary supply of nutrients to the fetus as well as result in potential harm to both mother and fetus due to induced ketosis. An inadequate weight gain during pregnancy leads to low birthweight infants and potential complications. In recent years, the recommendations for weight gain during pregnancy have been liberalized in response to expanded knowledge. At present, a gain of 22 to 25 pounds is considered desirable.¹¹

Protein needs are increased by 30 g/day (1.4 g/Kg/day) during pregnancy. In very young prospective mothers, under 15 years of age, the recommended intake is 1.7 g/Kg/day.

Since both plasma and erythrocyte volume increase at this time, the requirement for iron is increased (750 mg is the total cost of pregnancy).¹² Iron deficiency during this time results in maternal anemia. Less severe effects are seen in the fetus since it tends to deplete maternal iron stores. An iron supplement of 30 to 60 mg is recommended during pregnancy.

The increased maternal erythropoiesis (formation of red blood cells) and growth of fetal and placental tissues also result in an increased requirement for folate. Low, pre-pregnancy folate levels, due to either poor nutrition and/or long-term oral contraceptive use, indicate a need for supplementation during pregnancy of approximately 400 to 800 µg/day.

The RDA for calcium during pregnancy is increased from 800 mg to 1200 mg to allow for the increased needs of the mother and the fetus. While there is an adaptive ability to

increase calcium absorption and decrease excretion during this time, an inadequate intake may lead to osteomalacia (increased brittleness of bone) in the mother and a decreased bone density in the infant.¹³

The requirement for vitamin D, essential for calcium metabolism, increases 50 to 100 percent during pregnancy. However, it must be noted that maternal hypervitaminosis as a result of overdosing with this fat-soluble vitamin may lead to the more serious problem of infantile hypercalcemia.

The slightly increased needs for other vitamins and minerals during this period usually can be satisfied by adherence to a nutritious, balanced diet. A maintenance-level, vitamin-mineral supplement is often recommended but *megadoses must be avoided*. The maternal-fetal nutrient exchange is somewhat more complicated than the commonly accepted concept of fetal parasitism. The old belief that the fetus obtained all the nutrients it required from the mother, regardless of what she ate, has been refuted. The nutritional deficiencies of the mother significantly affect the nutritional status of the newborn.

LACTATION

The nutritional cost of lactation to the mother includes the energy required to synthesize lactose, proteins and fats as well as the nutrients extracted from the mother's plasma for milk production.

To make up the calorie deficit, the lactating woman should add 600 to 800 Kcal per day to her normal daily intake. The average 4 Kg of fat deposited by a woman during a normal pregnancy helps to provide the energy requirement of the offspring.

The nutrients for which there are the greatest demands on the lactating mother are calcium (an additional 400 mg calcium are required) and vitamins A and C. In the lactating women with a low calcium intake, a higher proportion of dietary calcium is absorbed and transported across the intestine. Human milk supplies sufficient vitamin C for the infant but is a poor source of iron. As a result, iron supplementation is usually prescribed after the first four to six months of life.

A low intake of energy reduces the volume of milk secreted without affecting its basic composition. However, the vitamin intake of the mother greatly influences the concentration of vitamins in milk. If her diet lacks certain vitamins or minerals, the milk will contain lower than normal levels of these nutrients. In general, there is variability in milk composition depending on race, climate, state of lactation and maternal diet.

MENOPAUSE

Women of postmenopausal age are more often subject to osteoporosis as a result of poor calcium and vitamin D nutrition and the drain of these nutrients by numerous pregnancies. This problem occurs in approximately 30 percent of women. Among the therapeutic regimens are estrogen administration (which may present some hazards), increased muscular activity, and adequate intakes of calcium (800 to 1200 mg/day) and vitamin D. Over-ingestion of high phosphorus-containing foods (as in high animal-protein diets) leads to a diet with a higher P/Ca ratio and may enhance osteoporosis.¹⁴

SUMMARY

In general, the nutritional requirements for women are

different and are more variable during the life cycle than they are for men. Extra nutrient demands resulting from menstrual losses, oral contraceptive administration, pregnancy and lactation, and probably menopause are important considerations in assessing the nutritional status of women.

REFERENCES

1. *Recommended Dietary Allowances*, 9th edition, Washington, D.C., National Academy of Sciences, 1980.
2. Herbert V: Introduction to the nutritional anemias. *Semin Hematol* 7:2, 1970.
3. Sturgeon P, Shoden A: Total liver storage iron in normal populations of the U.S. *Am J Clin Nutr* 24:469, 1971.
4. Caloric intake values for persons aged 1-74 years by race, sex, income level and age: Mean, standard deviation, standard error of the mean, and selected percentiles, United States. *Dietary Intake Source Data-United States*. 1971-74. DHEW Publication No. (PHS) 79-1221, Hyattsville, MD, Sept., 1979, National Center for Health Statistics, pp 1-5.
5. Adams PW, *et al*: Effect of pyridoxine hydrochloride upon depression associated with oral contraception. *Lancet* 1:897, 1973.
6. Prasad AS, *et al*: Effect of OC agents on nutrients. *Am J Clin Nutr* 28:377, 1975.
7. Wilde J, *et al*: Vitamin A, pregnancy and OC. *Br Med J* 1:57, 1974.
8. Bamji MS, Ahmed F: Effect of oral contraceptive steroids on vitamin A status of women and female rats. *Wld Rev Nutr Diet* 31:135, 1978.
9. Lumeng L, *et al*: Effect of OC on the plasma concentration of pyridoxal phosphate. *Am J Clin Nutr* 27:326, 1974.
10. Rivers JM: OC and ascorbic acid. *Am J Clin Nutr* 28:550, 1975.
11. Balsley M: Soon to come: RDA. *J Am Dietet Assoc* 71:149, 1977.
12. Kitay DZ, Harbort RA: Iron and folic acid deficiency in pregnancy. *Clinics Perinatol* 2:255, 1975.
13. Krishnamachari KA, Lyengar L: Effect of maternal malnutrition on the bone density of the neonates. *Am J Clin Nutr* 28:482, 1975.
14. Conacher WDH: Metabolic bone disease in the elderly. *Practitioner* 210:351, 1973.

Selected Abstracts with Comments

Hitch DC, et al: Recognition of bilateral neonatal testicular torsion. *Arch Dis Child* 55:153, 1980

Two cases of bilateral neonatal testicular torsions are reported. The clinical presentations of unilateral and bilateral neonatal testicular torsions are similar: (1) swollen bluish-red scrotum at birth; (2) firm testes without any evidence of spontaneous pain; (3) no systemic symptoms; (4) infant is of term gestation. Other causes of testicular swelling in this age group are acute hydrocele, hematoma, strangulated inguinal hernia, epididymitis or orchitis, testicular tumors and meconium peritonitis with a patent processus vaginalis.

Comment: Immediate scrotal investigation is essential to prevent testicular atrophy since, in experimental animal models, Leydig cells become totally necrotic after ten hours of vascular occlusion. (C. Uy, M.D.)

Kosloske AM, et al: Indication for operation in acute necrotizing enterocolitis of the neonate. *Surg* 87:502, 1980

A study to evaluate criteria for operation was carried out in 61 infants with acute necrotizing enterocolitis (NEC). Indications for operation *verified* by this study were (1) pneumoperitoneum, (2) paracentesis findings positive for gangrenous intestine, (3) erythema of the abdominal wall, (4) a fixed abdominal mass, and (5) a persistently dilated loop of intestine on serial abdominal radiographs. Operative indications which proved to be *invalid* in this study were (1) clinical deterioration, (2) persistent abdominal tenderness, (3) profuse lower gastrointestinal hemorrhage, (4) the roentgenographic finding of gasless abdomen with ascites, and (5) severe thrombocytopenia.

The mortality rate among the infants operated on after free intestinal perforation had occurred (64 percent) was *double* that of infants operated on for intestinal gangrene without perforation (30 percent). Paracentesis may identify infants with intestinal gangrene prior to the development of perforation and may permit advantageous timing of operation.

Comment: Neonatal necrotizing enterocolitis is a very complex disease. Cooperation between the neonatologist, the pediatric surgeon, the radiologist and the pediatric anesthesiologist is of utmost importance to accomplish satisfactory results. Early pediatric surgical consultation when the neonatologist starts to think about NEC in an infant is mandatory. *Paracentesis* should be done by the pediatric surgeon with the help of the neonatologist. (S. Saad, M.D.)

Morrison JA, et al: Interrelationship between nutrient intake and plasma lipids and lipoproteins in schoolchildren aged 6 to 19. *Pediatr* 65:727, 1980

One thousand six hundred and sixty-nine schoolchildren,

aged 6 to 19 years, black and white, male and female, were studied for nutrient intakes with relation specifically to plasma cholesterol and triglyceride, plasma low and very low density lipoprotein (C-LDL and C-VLDL) and also high density lipoprotein (C-HDL) determinations. With increase in sucrose intake, total plasma cholesterol and high density lipoprotein cholesterol fell while triglyceride rose. Increase in caloric and total carbohydrate intake caused a rise in triglyceride, while an increase in caloric intake resulted in a fall in high density lipoprotein cholesterol. With increase in polyunsaturate ingestion, plasma low density lipoprotein cholesterol increased.

Nutrient data were obtained by 24-hour dietary recall, supervised by nutritionists.

Comment: This is another good article from this well-established Lipid Research Clinic in Cincinnati. It's worth reading if for no other reason than to get used to terms such as C-LDL, C-HDL, and others. Just as we had help from a task force on pediatric essential hypertension, perhaps now is the time for a task force to guide us on cholesterol and triglycerides and the "prudent diet" for children to decrease coronary artery disease in the adult. Confusing! Experience teaches us: a) to instruct parents in *early* infancy on proper nutrition for their babies without adding salt and refined sugars and delaying the addition of solids and b) that, generally speaking, if the entire family does not eat a prudent diet, usually the success rate for the individual in question is poor. (M. Prystowsky, M.D.)

Kulig JW, et al: Experience with copper-7 interuterine device (Cu-7 IUD) in an adolescent population. *J Pediatr* 96:742, 1980

The records of 120 adolescent patients who received Cu-7 IUD were reviewed. The continuation rate and subjective satisfaction were high. The pregnancy rate and expulsion rate were low. The authors conclude that Cu-7 IUD has proved to be a safe, effective, well-tolerated contraceptive method.

Comment: The use of Cu-7 IUD has proved to be an effective method of birth control primarily because its use is independent of intercourse. However, the disadvantages of the method include the need to see a physician, coexistent

*Abstracted from the *Department of Pediatrics Newsletter*, CMDNJ, New Jersey Medical School, Newark—Vol 2, No. 6 (June) 1980. Selections are made by Richard H. Rapkin, M.D., Professor of Pediatrics and Medical Director of Children's Hospital, Newark, who is editor; Franklin C. Behrle, M.D., Professor and Chairman of Pediatrics; and Shyan C. Sun, M.D., Associate Professor of Pediatrics and Director, Department of Neonatology, Children's Hospital, Newark, who are coeditors. Comments are prepared by them and their associates.

early pregnancy, uterine perforation and the pain at the time of insertion, and the lack of protection against sexually transmitted diseases, an initial high incidence of reported side effects, late partial IUD expulsion and, most importantly, the potential long-term sequelae leading to infertility after insertion. IUD use has been associated with a three- to fivefold increased incidence of pelvic inflammatory disease (Ory HW: *J Reprod Med* 20:200, 1978) and, therefore, we limit its use to adolescents who have had a previous pregnancy or who cannot use other methods. If insertion is performed during menses and the uterus is sounded, the complications at the time of insertion can be avoided. (J.F. Russo, M.D.)

Litt I, et al: Identifying adolescents at risk for noncompliance with contraceptive therapy. *J Pediatr* 96:742, 1980

The records of 96 sexually active female adolescents were reviewed to determine the predictors of compliance with contraceptive use. "Compliance was found to correlate positively with postmenarchal age, frequency of intercourse, autonomy in making and paying for a clinic appointment specifically for the purpose of obtaining contraception, and acceptance of a method at the time of the initial clinic visit."

Comment: Drs. Litt *et al.* have eloquently demonstrated the importance of psychosocial maturation in contraceptive use. Those adolescents who have progressed to a psychosocial position at which they can make independent decisions are those who are most likely to comply. I might add that early sex education would enhance this process. (R. Johnon, M.D.)

D'Angio GJ, et al: Wilm's tumor: An update. *Cancer* 45:1791, 1980.

The mortality rate for Wilm's tumor has declined from 90 percent in the early 1900's to 10 percent with current management. Statistics have improved with better surgical technique, with the addition of postoperative radiation therapy and with adjuvant chemotherapy.

In 1969 the National Wilm's Tumor Study (NWTs) was begun enlisting numerous institutions in a cooperative effort to achieve a multi-modal management giving the best survival with the least toxicity. The results of NWTs I completed in 1974 showed: (1) children with limited disease who were less than two years of age realized no additional survival advantage with postoperative radiation; (2) children with disseminated disease, all of whom received postoperative radiation therapy, did better with a combination of vincristine and dactinomycin than with either drug alone; (3) favorable and unfavorable histology was defined and seen as a prognostic factor; (4) radiation doses were defined which give good results without much toxicity.

NWTs II is currently in progress and is looking at: (1) whether in localized disease patients adding vincristine to dactinomycin can compensate for omitting postoperative radiation in older children as well as in those less than two years old; (2) whether in limited disease six months of chemotherapy is as efficacious as 15 months; and (3) whether in disseminated disease the addition of adriamycin to vincristine and dactinomycin will improve survival rates. Preliminary results indicate excellent survival (90 percent) in localized regardless of age or whether the drugs are given for 6 or 15 months. Also the addition of adriamycin improves survival in disseminated disease.

Comment: This article is a complete and concise historical account of the achievement made in the management of

Wilm's tumor. And as pointed out in the discussion, this tumor serves as a model in demonstrating the benefits of integrated study through cooperative group efforts. Cooperative groups allow for accrual of large numbers of patients making results statistically more significant; set up a forum for multiple experts to share views which enable researchers to better define prognostic factors and have seemed to accelerate the progress made in survival for a number of childhood cancers. (B. Ryan, M.D.)

Martinson IM, et al: Home care for dying children. *Hastings Center Report*, April 1980, pp 5-7

Reactions and attitudes of outside individuals and institutions (e.g., police and third-party payers) posed problems for participants in a model project for home care of dying children. Most problems related to the fact that the child died at home rather than in a hospital. Unfortunate incidents arising from bureaucratic inflexibility in the face of the "unusual" seemed especially common in urban areas. However, agencies were eager to accommodate when problems occurred.

Comment: If we in urban children's hospitals are to be "part of the solution, not part of the problem," we must be willing to invest efforts in assuring that community agencies learn of the special needs of families caring for our dying patients at home. (D. Price, Ph.D.)

Mahoney CP, et al: Chronic vitamin A intoxication in infants fed chicken liver. *Pediatr* 65:893, 1980

Seven-month-old twin infants developed vomiting, irritability and bulging fontanelles. Spinal taps were normal. CAT scan revealed enlarged ventricles in both infants and slightly enlarged subarachnoid space in one. Daily diet included 40,000-44,000 I.U. of vitamin A for four months, contributed mainly by chicken liver (36,000 I.U./120 gms). This daily vitamin A intake was ten times recommended daily allowance. Plasma vitamin A concentrations were elevated. The mother of these infants prepared her own baby foods because she was concerned about preservatives and other additives in commercial preparations.

Comment: There has been an increase in the awareness of "carcinogenic effects" of preservatives and additives so that "natural foods" are sought after. The above case report illustrates the need of knowing recommended daily allowances of food. Megadoses can be toxic. (C. Uy, M.D.)

Oski FA, et al: Inhibition of iron absorption from human milk by baby food. *Am J Dis Child* 134:459, 1980

Adult volunteers who ingested a test meal of human milk were fed either a jar of baby food in addition or nothing. Iron absorption from the milk was reduced when the baby food was added. The bioavailability of iron in breast milk is reduced by solids.

Comment: The excellent iron absorption from breast milk may be compromised by the introduction of solids.

Miller JM, et al: Bacterial colonization of amniotic fluid from intact membranes. *Am J Obstet Gynecol* 136:796, 1980

Except in rare instances, intact membranes have been considered to be a barrier to infection of amniotic fluid. The authors collected amniotic fluid from 45 selected patients by amniocentesis or needle amniotomy prior to or during labor. Fluid was cultured and examined directly by gram stain. Among 14 patients who were not in labor, only one (7 percent) had growth of bacteria. Among 31 patients in labor,

13 (45 percent) were positive on primary plating media. These data demonstrated a wider spectrum of bacteria capable of colonizing amniotic fluid in the presence of intact membranes than was previously appreciated, indicating that direct gram stain in addition to culture can provide valuable diagnostic information.

Comment: The incidence of colonization of amniotic fluid in the presence of intact membranes and the frequency with which this event subsequently leads to premature labor and maternal and/or fetal and neonatal infection have not yet been established. The authors clearly demonstrated the presence of labor further increased the risk of amniotic fluid infection from 7 to 45 percent. During the past year, we have had three preterm infants succumb within 72 hours of birth to group B beta streptococcal sepsis in our Neonatal Intensive Care Unit, although there were no suggestive indications whatsoever that they were exposed to the risk of perinatal infection. All three had intact membranes up to the last minutes of labor. This again shows the dilemma of a pediatrician when he is faced with a difficult question of whether or not to use antibiotics on a sick neonate. The absence of premature rupture of membrane certainly is not a safety blanket for ascending infection during labor and delivery. (S. Sun, M.D.)

Babcock D, et al: B-mode gray scale ultrasound of the head in the newborn and young infant. *Am J Radiol* 134:457, 1980

The authors demonstrated a technique using commercially available B-mode Gray Scale ultrasonography for imaging the head in the newborn and young infant. Images of technical quality previously unobtainable are shown. Sixty-three normal and 48 abnormal patients were studied. Most of the information is obtained while scanning through the open sutures and fontanelles. Technically adequate examinations are obtained only in children under the age of about two years while sutures remain open. Normal and abnormal structures such as porencephalic cysts, developmental anomalies, intraventricular and intracerebral hemorrhages, cephalohematomas, subdural hematomas and arteriovenous malformations were demonstrated. Ultrasonography also proved to be an excellent method for following ventricular size and shunt function.

Comment: A-mode one-dimensional ultrasonography was used to detect shifts of the middle intracranial structures in 1955. Since then, ultrasonography has made many scientific advances—B-mode, Gray Scale, real-time and T-M (true motion) imaging, and so on—and the time will come soon for computerized ultrasonography similar to computerized tomography (CT). Ultrasonography has several advantages compared with CT, angiography, pneumo-encephalography and other methods of evaluating the brain. It uses non-ionizing radiation; it is painless, non-invasive, safe (insofar as we now know) and portable. No sedation is necessary in most infants. The cost of ultrasound equipment and examinations is lower than CT. Recent CT studies have revealed that close to 80 percent of infants less than 1500 gm birthweight treated in a NICU had evidence of intracranial hemorrhage. A portable ultrasound machine is most useful and convenient at the bedside for early detection and follow-up of intracranial pathology of these infants. It generally is accepted that the simplicity, safety, portability, and economics of ultrasonography make it highly desirable as a non-invasive diagnostic procedure. This is particularly true where CT scanning is not available or difficult to obtain. Ultrasonography of the head is still in its infancy. I expect to see

more studies in the coming year. (S. Sun, M.D.)

Cohen AN, et al: New concepts in phototherapy. *Pediatr* 65:740, 1980

Photoisomerization of bilirubin is the major mechanism of bilirubin photocatabolism. Phototherapy has been used for at least ten years with few serious problems (all of which are remedied by discontinuation). No evidence, even anecdotal, exists for potential long-term problems. The dangers of exchange transfusion are well known and "... weighing the very real ... risks of neonatal hyperbilirubinemia and exchange transfusions against the theoretical or unusual complications of light treatment, there is no current reason for discontinuation of the use of phototherapy." The principles of "phototherapeutic detoxification" might be applicable to other toxins and drugs.

Johnson DK, et al: The changing role of cystoscopy in the pediatric patient. *J Urol* 123:232, 1980

All children undergoing cystoscopy at Michigan Children's Hospital during 1977 were reviewed. It was of little benefit in the evaluation of recurrent urinary infection, enuresis or hematuria. It was valuable to evaluate obstruction and congenital defects. "Cystoscopy is used too often in the pediatric patient and frequently is without diagnostic or therapeutic benefit to the child."

Fleisher GR, et al: Falsely normal radionuclide scans for osteomyelitis. *Am J Dis Child* 134:499, 1980

Three children with unequivocal osteomyelitis had normal technetium scintigrams. Although bone scans are reliable they are not perfectly sensitive.

Comment: It is important for the pediatrician to keep his wits about him and recognize that clinical judgment cannot be suspended because of a normal bone scan. Very few patients with osteomyelitis will be afebrile, have a normal ESR, a normal WBC and differential, a normal physical examination, negative blood cultures and a normal bone scan but any or even several of these tests may be normal. Careful observation while treating on suspicion will clarify the situation in virtually all patients.

McCracken GH, et al: Intraventricular gentamicin therapy in gram-negative bacillary meningitis of infancy. *Lancet* 1:787, 1980

A multicenter study demonstrated that the addition of intraventricular gentamicin to standard antimicrobial therapy of neonatal meningitis worsened the outcome. The mortality rate was three times as great in the group receiving the intraventricular antibiotic.

Comment: This study has several lessons:

1. Uncommon disease is best assessed and treated in cooperative multicenter trials.
2. Experimentation should be done only under study protocols—not by individual physicians "trying" new therapies.
3. Anecdotal data may be at variance from well controlled prospective trials.
4. Even well-planned studies are not perfect: this study failed to separate those infants with obstructed ventricles, the group most likely to need ventriculostomy or instillation of local antibiotics. Another study needs to be done to assess best treatment for that group.

At present, neonatal gram negative meningitis remains a very difficult problem with an unacceptable level of morbidity and mortality and no clear-cut remedy.

Smith CR, et al: Double-blind comparison of the nephrotoxicity and auditory toxicity of gentamicin and tobramycin. *N Engl J Med* 302:1106, 1980

Tobramycin and gentamicin toxicity were compared in adults in a rigorous double-blind prospective fashion. There were no differences in auditory toxicity. Tobramycin caused significantly less nephrotoxicity. This difference "... may be important and is currently the only clinical difference that has been demonstrated between gentamicin and tobramycin."

Comment: Pediatric use of gentamicin will continue to be much greater than tobramycin because of our long experience with the former and because similar studies of comparative toxicity have not been done on children, nor has gentamicin toxicity been a problem.

Comerci GD: Presidential Address, The Ambulatory Pediatric Association, May 1, 1979. *Pediatr* 65:828, 1980

The good medical educator "... must be an interpreter or translator and have the gift or learned skill of being a facilitator of learning ... a scholar [need not] be involved in or accomplished in research ... clinician teachers deserve a place in academic medicine ... [they] must document their teachings and clinical efforts and evaluate their work in order to prove their worth ... [they] must remain role-models and not sacrifice this function in order to satisfy inappropriate and unrealistic requirements of university promotion and tenure committees. ..."

Comment: Dr. Comerci is an example of a former practitioner now clinician-educator who preaches what he has practiced. I agree with his thesis of the value of educators. I want to emphasize, though, that I believe everyone in academic medicine should be productive and tell others in some way, what he thinks. The way ought to allow for criticism and correction of missteps. Unless there is such a mechanism for interaction with colleagues in some formal fashion, the academician may succumb to the dangers facing the solo practitioner: repeated errors not recognized as errors becoming "experience."

Adamson G, et al: Home or hospital births. *JAMA* 242:1932, 1980

Advocates of home birth (opponents of hospital birth) cite:

1. Psychological advantages to the parents, the newborn and its siblings.
2. Maternal-infant bonding takes place more easily at home in a relaxed environment, surrounded by familiar and supportive attendants.
3. Selected statistics and studies from Frontier Nursing Service of Kentucky, Chicago Maternity Center, Sweden, Denmark, Holland, and England, indicate that home births can be as safe as hospital births.
4. The perinatal mortality in some countries with home births is lower than in the United States.
5. Often hospitals and physicians are authoritarian and impersonal.
6. There is excessive intervention in what is considered to be a natural event by procedures such as routine C/S, oxytocin stimulation, routine monitoring, routine use of sedation, artificial rupture of membranes, supine position for women in labor, all of which incur certain unique hazards not found at home.

7. There is the high cost of hospitalization.

Advocates of hospital birth (opponents of home birth) cite:

1. At least 20 percent of preventable perinatal mortality and 30 percent perinatal morbidity occur in the low-risk population and therefore are not apparent before labor. Major threats to the life and health of the fetus such as placental abruption and cord prolapse may occur as late as the second stage of labor.
2. Up to 50 percent of all twin pregnancies which represent a particular hazard are undiagnosed until the time of birth. The second twin has a 13 percent risk of death.
3. All births are to some extent high risk (more than one-half of all perinatal deaths occur during labor and in the first day of life). A normal delivery does not preclude the subsequent asphyxiation of the infant at birth. The delay necessitated in the transfer of mother and infant to the hospital for treatment of the above situation can result in a considerable poorer outcome for the infant. Even five minutes spent waiting for help for a hypoxic baby can be fatal for the infant.
4. Statistics and studies from the United States and abroad show that out-of-hospital births pose approximately a greater risk of two to five times to the mother and infant's life than do hospital births.
5. Medical backup rarely is obtained on an organized basis for home delivery. Data from one state showed that 40 percent of home births were attended by people without any type of health profession license.

The authors concluded that present data are limited and do not conclusively support either opinion of advocates for home or hospital births. It is essential that the medical profession become actively involved in an objective analysis of the merits and deficiencies of home and hospital birth settings. This participation should ensure that new approaches to birth will maintain the highest possible standards in maternal, fetal and neonatal welfare.

Comment: The first priority of childbirth is a live and healthy mother, the second a live and healthy baby, and the third a psychologically rewarding experience for the parents and the baby. Every person has the right to choose where to deliver her baby. But also, every baby has the right to be born safely. Because of the lack of backup systems in the United States, it is important for everyone to recognize the risks of home birth. To deny the existence of these risks is to deny the opportunity to avoid those that can be prevented and to manage successfully those that cannot be prevented. The British have had a sophisticated system of "flying squads" to help manage complications of home births. Despite this elaborate system, however, many flying squads are now being disbanded because of cost, efficiency and safety factors as well as decreased demand and alternatives in hospital care. Alternative methods of birthing practices that maintain the highest possible standards in maternal, fetal and neonatal welfare, while also serving the individual needs of the family may be the answer to the future. In fact, most of the New Jersey hospitals have already responded to the advocates of home birth by allowing different methods of delivery to be used such as: allowing fathers to be present during delivery; developing birthing rooms in the hospital to mimic the home environment. I personally believe every baby should be delivered at the hospital where efforts are made to create a relaxed home environment and encourage maternal-infant bonding. (S. Sun, M.D.)

a group major medical plan for doctors

Officially Endorsed by The Medical Society of New Jersey

**BROAD COVERAGE
COMPETITIVE RATES
OPEN ENROLLMENT
JUNE AND DECEMBER**

For More Information Contact

Donald F. Smith and Associates

1 Airport Place, Route 206 North, P.O. Box 2197 • Princeton, New Jersey 08540 • (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross-Blue Shield

DOCTORS' NOTEBOOK

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

There seems to be a widespread feeling that the new Republican administration will remove most of the regulations and cost controls affecting the "health care industry." This attitude surfaced during the AMA meeting in December. Following spirited debate in the reference committee, the House of Delegates voted, 104 to 100, to encourage elimination of all government-directed peer review programs, including PSRO. A motion advocating repeal of health planning legislation also passed. Without taking political sides, or liberal-conservative postures, some reflection on this trend is indicated.

Most of the cost-containment measures in recent years have been signed by Presidents Nixon and Ford. PSRO was part of Public Law 92-603, signed by President Nixon. Also included in P.L. 92-603 are utilization regulations for Medicare and Medicaid which are *not* subject to PSRO. If PSROs disappear, these other regulations will prevail. The net effect will be to remove physician participation from the decision-making process, although doctors will continue to bear the responsibility. While repeal of PSRO may be possible, the elimination of all of P.L. 92-603 is most unlikely.

The Health Planning and Resources Development Act, Public Law 93-641, was signed by President Ford. This established the Health Systems Agencies (HSAs) and the Certificate of Need process. Should this law disappear, New Jersey's own health planning regulations will remain in effect. The potential linkage between regionalization of services, including certificate of need, and the prospective reimbursement system using DRGs has been mentioned here previously. Given the interest of the

Health Care Financing Administration in the DRG effort in this State, it seems unlikely that both the national and local efforts to control hospital cost will be abandoned.

The incoming President's Transition Team included a number of advisers on medical matters. Among them are Professor Alain Enthoven¹ of Stanford University, whose Consumer Choice Health Plan, a form of National Health Insurance, is held in high regard in Washington. In a recent book, he relates how Medicare costs double every four years, to a total of \$34 billion in 1980. "Government will be forced to act to bring health care spending under control," he adds. Clark Havinghurst, a professor at Duke University law school, is another adviser. He is also a key adviser to the Federal Trade Commission, and wrote much of FTC's stand on physician "control" of Blue Shield Plans and IPAs (but not HMOs). Both Enthoven and Havinghurst favor the promotion of forces in health care.

The new Secretary of Health and Human Services (HHS) is to be former Senator Richard Schweiker of Pennsylvania. He has been ranking minority member of the health sub-committee of the Senate Labor and Human Resources Committee (this was written prior to the confirmation process). In a television interview in December, Senator Schweiker said that the HHS budget was \$222 billion, which is one-third of the Federal budget. Ninety-four percent of this is tied to entitlement programs, which can be changed only by legislative action. The remaining six percent can be worked on to control costs. This will entail, in Mr. Schweiker's opinion, reducing waste, fraud, and abuse. You can be sure that all three categories will be analyzed for consumption by physicians, hospitals, and other "providers." Each of the entitlement programs, many of which involve personal benefits to individuals, has its vocal advocates who can be expected to support its continuance. The voice of organized medicine will have to contend with these groups for the attention of the Congress.

Unless inflation is lessened considerably, removal of all cost-containment measures is not likely. The entitlement programs will cost more, since many are tied to cost-of-living increases. There may be more of a squeeze on the remaining six percent. Medical cost control efforts, in one form or another, will remain. There will be some modification of existing programs. There should be a role for organized medicine in analyzing and monitoring such modifications, if only to prevent the obliteration of all physician input. Your Foundation has seen the Nixon, Ford, and Carter administrations, and we have not noticed any lessening of the interest in reducing medical and health care costs. We will be very surprised if the Reagan administration abandons all such efforts.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

For more than half of the ten years that CMDNJ has been in existence, the College has benefited greatly from the support of the Foundation of CMDNJ through its annual grants' program for educational enrichment, research student assistance, community health projects and new College ventures in health care.

Awards in this program have totaled more than \$3 million since the Foundation of CMDNJ was established in 1974. Composed of New Jersey business, professional, civic and foundation leaders, the Foundation of CMDNJ is a non-profit corporation which supports excellence in education, research and service at the College, with the goal of improving health care for the people of New Jersey. The Foundation's resources complement—they do not replace—the State's obligation to operate the College.

Currently serving as chairman of the Foundation is David J. Sherwood, president of the Prudential Insurance Com-

¹Enthoven AC: *Health Plan: The only Practical Solution to the Saving Cost of Medical Care*. Reading, Mass., Addison-Wesley Publishing Company, 1980.

pany of America. Richard J. Bennett, chairman and chief executive officer of Schering-Plough Corporation, is president; Everett M. Scherer, a partner in the law firm of Riker, Danzig, Scherer, and Hyland, is secretary; and Edward R. Eberle, retired board chairman of Public Service Electric and Gas Company, is treasurer.

In the Foundation of CMDNJ's 1980-81 annual award cycle program, faculty members from the College's three medical schools along with its dental school have been awarded 19 research grants totaling \$396,863. The researchers are working on such varied projects as studying the effects of the industrial pollutant cadmium on the human body, factors regulating lung metabolism and the function of genes during their development state.

The cadmium project, under the direction of Bernard D. Goldstein, M.D., professor and chairman of the Department of Environmental and Community Medicine at CMDNJ-Rutgers Medical School, is designed to help explain why and how this common metal element in the air is linked to heart, kidney and bone diseases. The complex study involves probing the effects of cadmium in laboratory mice, discovering the problems it brings, and the ill effects it has.

At the CMDNJ-New Jersey Medical School researchers are involved in the investigation of orthopedic problems in two separate projects funded by grants from the William Lightfoot Schultz Foundation which are being administered by the Foundation of CMDNJ.

Back pain, historically one of man's most persistent physical problems, is the subject of one intensive investigation. Under a three-year grant awarded to Casey K. Lee, M.D., assistant professor of orthopedic surgery at the school, two particular areas of interest to orthopedic surgeons and their patients are being studied: spinal fusion and scar formation around nerves following spinal surgery.

In the other project physicians and engineers at CMDNJ-New Jersey Medical School, using a variety of highly innovative multidisciplinary techniques, are tackling some of the most common and painful orthopedic problems, such as arthritis, damaged tendons and ligaments, and broken bones.

At the biomechanics laboratory in the school, one of only a handful of such facilities nationwide, a group of more than 20 surgeons, engineers, researchers and graduate students are applying the concepts of dynamics and energy used in

engineering research to the musculoskeletal system in studies designed to improve the efficacy of devices and techniques employed by orthopedic surgeons. The studies are under the supervision of Harold Alexander, Ph.D., associate professor of orthopedic surgery at the school and director of the biomechanics laboratory.

A cure for diabetic cataracts, one of the leading causes of blindness, is the target of a study by researchers at the CMDNJ-New Jersey Medical School, headed by Annette Beyers-Mears, Ph.D., associate professor of physiology. The research is being funded by both the Foundation of CMDNJ and the National Institutes of Health, which had designated CMDNJ as one of 20 major research centers nationwide in an effort to find the prevention and cure of cataracts.

The risk of developing cataracts by diabetics is four to five times greater than that of non-diabetics, because of the high blood glucose that enters the eye lens, causing a swelling and rupture of the cells around the lens perimeter. Working with neonatal laboratory rats, Dr. Beyers-Mears and her colleagues are investigating aldose reductase inhibitors as potential therapy for diabetic cataracts. The inhibitors already have been found definitely to arrest the growth of these cataracts, and the researchers are trying to determine if they actually can reverse that growth.

In a pilot health education project undertaken by the CMDNJ-Office of Consumer Health Education at the Piscataway campus, educators are aiming to enhance the recovery of heart attack victims and, it is hoped, to reduce the chance of a second attack. Known as "Project Upbeat," the multi-faceted approach to patient education employs individual teaching sessions, print and audiovisual material and group discussions. Research has shown that fear of a second attack is one of the main problems heart attack victims have to overcome.

Funded by a grant from the Prudential Insurance Company of America through the Foundation of CMDNJ, the program is based at John F. Kennedy Medical Center in Edison, Middlesex General Hospital in New Brunswick, Muhlenberg Hospital in Plainfield, and Perth Amboy General Hospital.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY—Eric J. Schenkel, M.D., Park Drive Manor, Apt. A-1212, Philadelphia, PA 19144. Einstein 1976. Also, general internal medicine. Board certified (IM). Group, partnership, academic. Available August 1981.

ANESTHESIOLOGY—Ramesh M. Nayak, M.D., 800 Sawyer Hall, 2910 Scioto Street, Cincinnati, OH 45219. Seth G.S. Medical (India) 1971. Board eligible. Solo, small group. Available.

Won S. Cho, M.D., 1303 Midmeadow Road, Towson, MD 21204. Korea University, 1963. Board eligible. Group, partnership, or solo. Available on one month's notice.

CARDIOLOGY—Sheldon Eisenberg, M.D., 300 Community Drive, Manhasset, NY 11030. Cornell 1976. Also, general internal medicine. Board certified (IM). Non-invasive techniques, hospital based, or single or multi-specialty group. Available July 1981.

Richard J. Butcher, M.D., Geisinger Medical Center, Danville, PA 17822. University of Pennsylvania 1973. Board certified (IM). Group or partnership. Available July 1981.

FAMILY PRACTICE—C. Chin, M.D., 1016 Washington Garden Apts., Washington, NJ 07882. SUNY-Stonybrook 1979. Board certified. Part-time clinic, ER or housestaff duty. Available.

Mark Scheier, M.D., 24 Paerdegat Third Street, Brooklyn, NY 11236. Guadalajara (Mexico) 1977. Board eligible. Group, partnership, multi-specialty group. Available July 1981.

Winthrop C. Dillaway, III, M.D., 322 W. 57th Street, Apt. 45-L, New York, NY 10019. Guadalajara (Mexico) 1975. Board certified. Solo (home office). Available.

Stephen Kay, M.D., 22745 Kelly, East Detroit, MI 48021. Innsbruck (Austria) 1949. Board eligible. Solo. Available.

GASTROENTEROLOGY—Jacques M. Schmid, M.D., 225-F Edgemoor Road, Bridgeport, CT 06606. Einstein 1976. Also general internal medicine. Board certified (IM). Any type practice. Available July 1981.

George J. Rezk, M.D., 7713 Fort Hamilton Parkway, Brooklyn, NY 11228. Bologna (Italy) 1976. Board eligible. Group or partnership. Available July 1981.

GENERAL PRACTICE—Carlos A. Viola, M.D., Avenida Cordoba 77 Oeste, San Juan 5400, Argentina, South America National University, Buenos Aires 1950. Also, general surgery. Institutional, group, or partnership. Available.

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule
contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCL	25 mg.
L-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine HCL	3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



HEMATOLOGY/ONCOLOGY—Frank Gentile, M.D., 654 Dahill Road, Brooklyn, NY 11218. Bologna (Italy) 1972. Board eligible. Solo, group, associate, partner. Available July 1981.

INFECTIOUS DISEASES—David Brooks, M.D., P.O. Box 33172, San Diego, CA 92103. Dublin (Ireland) 1962. Also general internal medicine. Available.

INTERNAL MEDICINE—David J. Stone, M.D., 105 Stewart Circle, Charlottesville, VA 22903. NYU 1974. Board eligible. Group. Available July 1981.

Howard Allen Sackel, M.D., 39 Cottonwood Drive, Stoughton, MA 02072. SUNY-Upstate 1976. Subspecialty, nephrology. Board certified. Group or partnership. Available July 1981.

Sharon D. Warner, M.D., 115 Old Short Hills Road, Apt. 274, West Orange, NJ 07052. SUNY-Downstate 1978. Board eligible. Partnership, single or multi-specialty group. Available July 1981.

Martin Lerman, M.D., 3258 Lauriston Place, Fairfax, Virginia 22030. Georgetown 1973. Board certified. Any type practice. Available.

Fayez A. Roumani, M.D., P.O. 522, Bradford, PA 16701. Damascus (Syria) 1973. Subspecialty, nephrology. Board eligible. Group or hospital-based. Available.

Steven Rosner, M.D., 150 Colton St., Apt. 3-D, Staten Island, NY 10305. New York Medical College 1976. Subspecialty, rheumatology. Board certified. Group, partnership. Available July 1981.

Robert J. Moran, M.D., 801 East 10th Street, Brooklyn, NY 11230. SUNY-Downstate 1977. Board eligible. Group, partnership, or hospital-based. Available July 1981.

Joseph A. Catapano, M.D., 298 Townhouse, Hershey, PA 17033. Rutgers 1976. Also, clinical cardiology. Board certified. Available July 1981.

NEPHROLOGY—Krishnababu Chunduri, M.D., 2121 Shore Parkway, Apt. 2-F, Brooklyn, NY 11214. Guntur (India) 1973. Board eligible. Solo or group. Available.

Vijay K. Nellore, M.D., 33-A West 23rd Street, Bayonne, NJ 07002. Osmania (India) 1973. Solo, group, or institutional. Available July 1981.

NEUROLOGY—Alan J. Friedman, M.D., 114 Adena Road, West Newton, MA 02165. Cornell 1974. Board certified (IM). Board eligible. Group or partnership. Available July 1981.

OBSTETRICS/GYNECOLOGY—Gary S. Rosenberg, M.D., 245-20 Grand Central Parkway, Bellerose, NY 11426. SUNY-Downstate 1977. Solo, group, partnership. Available July 1981.

Shreedhar P. Abhyankar, M.D., 15-J Sycamore Drive, Norwalk, OH 44857. B.J. Medical (India) 1971. Board eligible. Solo, partnership, group, (small or medium-sized town). Available.

ONCOLOGY—D. S. Prajapati, M.D., 88 Slate Creek Drive, #5, Cheektowaga (Buf-

falo) NY 14227. Baroda (India) 1972. Board certified. Group, partnership, solo. Available July 1981.

Steven E. Zimmerman, M.D., 7562 Westlake Terrace, Bethesda, MD 20034. Cornell 1976. Also, general internal medicine. Board certified (IM). Group or partnership preferred, also solo. Available July 1981.

OTOLARYNGOLOGY—Howard Taylor, M.D., 8201 Henry Avenue, Apt. P-3, Philadelphia, PA 19128. Columbia 1972. Board eligible. Partnership, group. Available July 1981.

PATHOLOGY—Kaushik J. Pandya, M.D., 30-49 70th Street, Jackson Heights, NY 11370. Baroda (India) 1974. Any type practice. Available July 1981.

Maneala V. Betkerur, M.D., 10015 S. Hill Terrace 28/202, Palos Hill, IL 60465. Karnatak (India) 1974. Subspecialty, neonatology. Board certified. Group, institutional. Available July 1981.

Aiyalam P. Sivaramakrishnan, M.D., 3520 Keystone Avenue, #3, Los Angeles, CA 90034. Seth G. S. Medical (India) 1971. Subspecialty, pediatric cardiology. Board certified. Group, institutional, hospital-based, HMO. Available.

Sitamahalakshmi Nutakki, M.D., 22 Metropolitan Oval, #5G, Bronx, NY 10462. Guntur (India) 1970. Board eligible. Group or partnership. Available.

Meera V. Bodas, M.D., 4 Manitou Way, Scotch Plains, NJ 07076. Nagpur Medical (India) 1967. Board eligible (AP/CP). Group (part-time also acceptable). Available July 1981.

PEDIATRICS—Anil G. Pradhan, M.D., 118 Grove Park, Fort Dix, NJ 08640. Bombay (India) 1972. Board certified. Solo, partnership, associate, group. Available March 1981.

Rajendra C. Parikh, M.D., 77-07 Woodside Avenue, Apt. 3-A, Elmhurst, NY 11373. Baroda (India) 1975. Board eligible. Group, partnership, solo, or institutional. Available June 1981.

Shara J. Doshi, M.D., 304 Fir Street, Raceland, Louisiana 70394. B.J. Medical (India) 1969. Board eligible. Solo, group, partnership, clinic. Available March 1981.

PSYCHIATRY—Florence Ouseph, M.D., 2200 South Rock Road, Apt. 1108, Wichita, Kansas 67207. Christian Medical (Vellore, India) 1975. Board eligible. Institution (VA Medical Center). Available November 1981.

RADIOLOGY—U. Chaibongsai, M.D., 992 Woodmere Drive, Westfield, NJ 07090. Siriraj (Thailand) 1968. Board certified. Part-time, group, partnership. Available.

Indu M. Solanki, M.D., 266 Beaufort Avenue, Livingston, NJ 07039. B.J. Medical (India) 1967. Board eligible. Solo, group, or partnership. Available.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379. Shah (India) 1969. General practice and rehabilitation medicine. Notice on three months' notice.

A peripheral vasodilator

for treatment of
**leg cramps
cold feet
tinnitus
discomfort on
standing**

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
In choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	.....300 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	.....250 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	.....100 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available July 1981.

Thomas A. Giangrosso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available July 1981.

SURGERY, GENERAL—Zahur U. Azhar, M.D., 1684 Central Avenue, Bridgeport, CT 06610. Nishtar (Pakistan) 1963. Board eligible. Solo. Available July 1981.

Darius Vaziri, M.D., 7510 Brompton Court, Apt. 587, Houston, TX. Tehran (Iran) 1974. Also, vascular surgery. Board eligible. Group, partnership. Available August 1981.

Carlos A. Viola, M.D., Avenida Cordoba 77 Oeste, San Juan 5400, Argentina, South America. National University, Buenos Aires 1950. Also, general medicine. Institutional, group, or partnership. Available.

S. W. Choi, M.D., 14 Phyllis Place, Milltown, NJ 08850. Seoul (Korea) 1967. Board certified. Group or partnership. Available.

Jawaid Akhtar, M.D., 21634 Stratford Court, Oakpark, MI 48237. Karachi (Pakistan) 1967. Also, colon and rectal surgery. Board certified (general and color and rectal). Solo, group, partnership, or associate. Available.

Ruben J. Delgado, M.D., 293 First Street, Mineola, NY 11501. Puerto Rico 1976. Also, vascular surgery. Board eligible. Group or partnership. Available July 1982.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available July 1981.

Inder J. Singh, M.D., WCMC #1-C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available July 1981.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available July 1981.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available June 1981.

UROLOGY—Elliott Lieberman, M.D., 16-66 Bell Boulevard, Apt. 730, Bayside, NY 11360. SUNY-Downstate 1976. Group or partnership. Available July 1981.

William Kohlberg, M.D., 3450-17A Wayne Avenue, Bronx, NY 10467. Pittsburgh 1975. Board eligible. Group or partnership. Available July 1981.

Paul A. Church, M.D., 435 East 70th Street, Apt. 27-C, New York, NY 10021. Cornell 1975. Board eligible. Solo, partnership, group. Available June 1981.

Vasant Betkerur, M.D., 10015 South Hill Terrace, 28/202, Palos Hill, IL 60465. Government Medical (India) 1973. Solo, partnership, group. Available July 1981.

Harvey Schoenbrum, M.D., 1249 Park Avenue, Apt. 14-A, New York, NY 10029. Pittsburgh 1976. Board eligible. Group, partnership. Available July 1981.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available June 1981.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available July 1981.

Robert D. Zimmerman, M.D., 206 Friar Lane, Clifton, NJ 07013. Chicago Rush-Presbyterian. Board eligible. Partnership, solo, group. Available July 1981.

ing's sarcoma, osteogenic sarcoma, and non-Hodgkin's malignant lymphoma (especially Burkitt's lymphoma) are eligible for these studies. Patients selected for the program generally will have received no previous definitive therapy. Clinical trials involve evaluation of new combinations of chemotherapy, radiotherapy, surgery, and biologic response modifiers. All patients accepted for admission to this branch also may be enrolled in studies of optimal supportive care techniques (e.g., autologous bone marrow infusion, platelet and granulocyte transfusion, and laminar air flow protective isolation). Patients may be admitted with any extent (stage) of their disease, except in the case of neuroblastoma and rhabdomyosarcoma studies which are restricted to extensive disease.

There will be no cost to the patient for evaluation, treatment, travel (except for the first trip), hospitalization, or ambulatory care related to these clinical trials.

Physicians interested in further details or in having their patients considered for admission may write or telephone: Attending Physician, Pediatric Oncology Branch, NCI, Building 10, Room 3B-12, National Institutes of Health, Bethesda, Maryland 20205—(301) 496-4256.

ACCP Fellows

The following members of the Medical Society of New Jersey have been elected to Fellowship in the American College of Chest Physicians and were inducted at ceremonies during the ACCP's 46th annual scientific assembly held recently in Boston:

Joseph M. Bordiuk, M.D., Hackensack
Mario A. Criscito, M.D., West Orange

NCI Clinical Center Study

The cooperation of physicians is requested in the referral of young patients with malignancies for studies being conducted by the National Cancer Institute, Pediatric Oncology Branch, at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Patients with acute leukemia, neuroblastoma, rhabdomyosarcoma, Ew-

215th Annual Meeting
May 15-19, 1981
Meadowlands Hilton, Secaucus
(See Housing Application, pages 110, 118, 127)

LETTERS TO THE JOURNAL

Handicapped Physicians

November 18, 1980

Dear Editor:

The St. Paul-Ramsey Medical Education and Research Foundation is involved actively in a project directed toward serving the needs of handicapped physicians. The purpose of this project is to form a voluntary group of handicapped physicians who will provide information and referral services as well as support and advocacy for physicians who become handicapped. I became multiply handicapped five years ago just as I was completing medical school and readily can attest to the paucity of information available to this unique population. Existing rehabilitation programs simply are not equipped to deal with the situation.

The biggest problem we are encountering is that of identification. It currently is estimated that four percent of all physicians are not in active practice because of a physically handicapping condition and that 25 percent of these have the potential to be rehabilitated into the active practice of medicine. In real numbers this constitutes one percent of the licensed physicians in this country, or 4,500 physicians. Our goal is to identify these physicians and encourage their participation.

As an aid in identification, I ask that all physicians, active or inactive, with any type of physical handicap, contact me at St. Paul-Ramsey Medical Education and Research Foundation, 640 Jackson Street, St. Paul, MN 55101.

(signed) Frank C. Zondlo, M.D.

Nuclear Conflict

November 18, 1980

Dear Dr. Krosnick:

Thank you for sending me a copy of the October, 1980, issue of *The Journal of the Medical Society of New Jersey*.

I certainly appreciate knowing of your thoughts about the importance of preventing a nuclear war. Also, I share your

deep concern about the extremely serious medical consequences of a nuclear weapons exchange between the Soviet Union and the United States. I have read your editorial regarding the incredible medical problems that would most likely result from a nuclear attack on a large metropolitan area with a great deal of interest.

As you may know, I have consistently opposed those policies that might aggravate nuclear proliferation problems. Moreover, I have supported earlier nuclear arms limitation agreements and I will continue to support the SALT process in the months and years to come.

Again, thank you for taking the time to bring your editorial and open letter to President Carter and Chairman Brezhnev to my attention. It is always helpful to me in my deliberations to have the benefit of such information.

(signed) Harrison A. Williams, Jr.
United States Senator

November 25, 1980

Dear Dr. Krosnick:

Thank you for your letter and the accompanying issue (October 1980) of *The Journal of the Medical Society of New Jersey* which carries an editorial on nuclear warfare.

Bearing in mind the potential horror of a nuclear conflict, I appreciate the necessity of keeping the lines of communication open between ourselves and the Soviet Union. I am sorry that the SALT negotiating process which made contributions to building mutual confidence has been undermined by the Soviet invasion of Afghanistan. I supported the decision earlier this year to defer further Senate consideration of SALT II because the international atmosphere has not been conducive to Senate review of the treaty on its merits. Nonetheless, I saw nothing in terms of the SALT II treaty that seemed to be inconsistent with our national security interests, and I hope that the United States and the Soviet Union will soon be able to recapture the momentum of con-

fidence building.

Once again, thank you for taking the time to let me know your views.

(signed) Bill Bradley
United States Senator

Carrier Foundation Proceedings

December 10, 1980

Dear Doctor Krosnick:

For almost a quarter of a century, the Carrier Foundation has been in the field of Medical Education and recently published a Commemorative Booklet reviewing the historical development of this educational effort.

In the beginning, copies of the proceedings were available but, as printing costs increased, it became impossible to continue. Nevertheless, we were successful in resuming publication of our 18th and 19th Symposia, and I am writing to advise my medical colleagues that copies of these publications are available for the asking. If you wish to obtain them, please send your name and address with \$1.00 for postage and handling to Robert S. Garber, M.D., Carrier Foundation, P.O. Box 147, Belle Mead, New Jersey 08502.

(signed) Robert S. Garber, M.D.
President, Carrier Foundation

Adolescent Breast Disease

December 15, 1980

Dear Doctor Krosnick:

I hate to be picayune. In regard to the article by Skiles and Seltzer, "Adolescent Breast Disease" in the December 1980 issue of *The Journal* (77:891-893), I must make a small protest. The most common adolescent breast mass is not even mentioned. Despite the title, the article discusses only *female* adolescent breast disease; male adolescents are not even considered. Because the occurrence of breast masses in males due to

gynecomastia is so prevalent, the psychological implications so severe, and the surgical treatment so straight-forward, I would have expected to see this matter discussed.

(signed) Richard B. Bloomenstein, M.D.

Update on Medicare Legislation

December 15, 1980

Dear Dr. Krosnick:

I thought you would be interested to know that some of the important provisions of pending legislation to liberalize the home health provisions in the Medicare program have cleared Congress and are now law.

Some of the most important and far-reaching changes will affect Medicare beneficiaries with regard to home health care. Specifically, the new law eliminates the current limit on the number of home health care visits reimbursed by Medicare. In addition, prior hospitalization as an eligibility requirement for home health benefits is no longer necessary

and the Medicare patient no longer will have to pay the \$60 deductible for such services.

These are very positive steps in the direction of diversifying medical treatment for older Americans who participate in the Medicare program.

I trust that this information will be of interest to you and your readers.

(signed) William J. Hughes
Member of Congress

Opposition to Federal Subsidy of HMOs

December 15, 1980

Dear Dr. Krosnick:

Getting a meaningful resolution through the House of Delegates is a Herculean task. Conflicting interests and varied philosophies compound the obstacles of parliamentary procedure.

Opposing federal subsidy of HMOs was so logical that, once it was adequately interpreted, there was little trouble in passage. Now Dr. Bernstein objects.

Perhaps this should be referred to the

Committee on Impaired Physicians. Apparently bleeding heart can cause cerebral anemia.

Dr. Bernstein contends that a patient who pays a deductible on an insurance claim is subsidizing his insurance company, and that the doctor who discounts his fee is doing the same. Were this a proper use of the word subsidy, which it is not, it would still be a matter of free choice on the part of the patient or doctor.

The Resolution dealt with *federal subsidy*. Would arbitrarily redefining the word federal alter the clear intent?

These subsidies, as *grants* and *unsecured* loans of public (yours and mine) money at preferential rates, are not what Dr. Bernstein suggests. The failures pay *nothing*.

The ultimate irony is that their propaganda claims such subsidies will increase *fair* competition. By definition the subsidy renders the competition *unfair*.

It is reassuring that we still see eye to eye when it comes to such a controversial issue as opposing a nuclear holocaust.

(signed) Frank J. Primich, M.D.

LETTERS FOR THE INFORMATION OF OUR READERS

JEMPAC Support

November 11, 1980

Doctors:

The November 1980 issue of *The Journal* illustrates the failure of physicians to be aware of what is being done to them by their own financial contributions.

Dr. Pinck wrote an appropriate editorial (77:798-799, (Nov.) 1980) warning us of the dangers of cost containment as proposed by the federal government. I agree with him. The following page in *The Journal* contains a report from JEMPAC, our political action committee. JEMPAC reports it took a non-partisan position by giving to eight

Democrats and seven Republican candidates.

What should concern you is that JEMPAC supported at least one Democrat incumbent who has for years fought for federal cost-containment programs of which Dr. Pinck warns us. That same incumbent has voted for no less than a dozen bills/amendments in the Congress which are in conflict with our profession and the patients we serve.

I know because I was the Republican candidate who ran against that incumbent. The non-partisan stand meant that JEMPAC contributed to both our campaigns. The only difference was that the incumbent, with his anti-medicine re-

cord, received four times the amount that was given to me, despite both my wife and I being members of the AMA, MSNJ, and the Gloucester County Medical Society with active local and state involvement (county Treasurer, Mental Health Committee, Judicial Committee).

In short, we cannot on one hand fight to limit federal control and regulation, and on the other financially support people who promote such federal involvement. But that is what we have been doing.

(signed) Scott L. Sibert, M.D.

JEMPAC Rebuttal

January 19, 1981

Dear Doctors:

All Congressional candidates in the November 4, 1980 general election carefully were evaluated by the JEMPAC Evaluation Committee composed of MSNJ physicians. The Committee used as its criteria personal knowledge and voting records of the candidates, as well as information gathered by AMPAC and its Washington lobbyists before deciding which candidates would receive financial support. Part of this major criteria is based upon the candidates' support of medical issues which are of significant importance to the medical community and by his/her electability and chance of winning.

Doctor Sibert was, without question, a candidate friendly to medicine, but with little or no chance of winning. JEMPAC, therefore, informed Doctor Sibert at the time he announced his candidacy that it would have great difficulty justifying financial support to his campaign. In deference to Doctor Sibert as a physician, a token contribution was made.

Although Mr. Florio had not supported medicine on all medical issues before Congress, he has been very helpful on a number of issues pertinent to

medicine. In addition, Mr. Florio's reelection to Congress was inevitable. JEMPAC, therefore, chose to support him financially. The result of JEMPAC's decision is given credence when one notes the election results—*Scott L. Sibert-42,154; James J. Florio-147,352*.

JEMPAC, in its use of the funds entrusted to it, is careful to consider all circumstances and possible consequences in its decisions concerning candidate support.

(signed) Frank Y. Watson, M.D.
Chairman, JEMPAC

Preventive Measures*

December 15, 1980

Dear Senator Bradley:

I note with interest your concern that physicians do not provide sufficient emphasis on preventive services, nor do they provide health education to encourage their patients to take greater individual responsibility for their own health.

I pledge to do my own part to see that my patients are not denied this advice.

I urge you, on your part, to seek an

end to federal crop supports for tobacco, support for mandatory seat belt and helmet laws, legislation to control the alcoholically impaired driver, and support for federal gun control laws.

Control of these dangerous substances would result in decreased mortality and morbidity to the American public from fire, cancer, lung disease and other injury to the vital organs, with a concomitant improvement in the health, well-being and life span of the American public far in excess of what could be achieved by the most massive program of medical preventive health care.

I would call to your attention that physicians practice what you preach, but that the federal government does not have the courage of its convictions, and has never shown that it is, in fact, the least bit concerned about the safety and health of the American people.

Control of these substances would reduce health care expenditures and permit the closure of numerous hospital beds now utilized by the end users of substances which the federal government either supports or fails to control adequately, and which are of known danger to the health of our citizens.

(signed) Robert A. Goldstone, M.D.

*This letter is in response to—Bradley B: Health care, quality and cost. *J Med Soc NJ* 77:604-605, (Aug) 1980.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physicians Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

LUPUS FACTS FOR YOUR PATIENTS

Lupus is the subject of a new Arthritis Foundation educational campaign.

The campaign theme is: "WHO'S AFRAID OF THE BIG, BAD LUPUS?... YOU ARE WHEN YOU KNOW WHAT IT MEANS." Using a wolf as an attention getter, we will seek to inform the public about the LUPUS problem in the U.S., and the help that is available. Our literature will provide the warning signs for the disease and our consumer ads and broadcast materials will stress early diagnosis and proper medication and therapy, as the only defense.

We urge your participation in this effort. Our new fact-filled lupus brochure, written for the layman, covers such subjects as what is lupus, the diagnosis of lupus, who gets lupus, the pattern of lupus, signs and symptoms, a management/treatment program and prevention guidelines. Simply order the desired quantities from your local Arthritis Foundation Chapter office, or write "Lupus," Arthritis Foundation, 3400 Peachtree Road, NE, Atlanta, Georgia 30326.

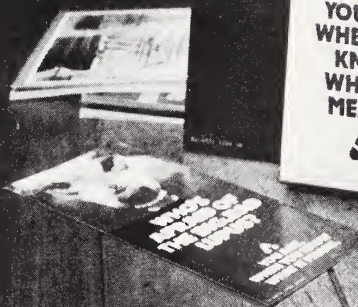
With your help, the impact of this lupus educational campaign will be just what the doctor ordered.



**WHO'S AFRAID
OF THE BIG, BAD
LUPUS?**



**YOU ARE.
WHEN YOU
KNOW
WHAT IT
MEANS.**



CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Mar.

- 11 Perinatal Pharmacology
8-9:30 p.m.—West Jersey Hospital,
Voorhees
(*West Jersey Hospital*)
- 21- Postgraduate Anesthesia Seminar
- 22 Hyatt House, Cherry Hill
(*NJ State Society of Anesthesiologists
and AMNJ*)

Apr.

- 8 Electrical Safety
8-9:30 p.m.—West Jersey Hospital,
Voorhees
(*West Jersey Hospital*)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Mar.

- 3 The First Breath
- 10 Difficult and Demanding Colo-Rectal Problems
- 24 Fiber in Relation to Heart Disease
- 31 To be announced
8-9 a.m.—Greater Paterson General Hospital, Wayne
(*Greater Paterson General Hospital and AMNJ*)
- 4 Ninth Joint Conference
All Day—Coachman Inn, Cranford
(*NJ Thoracic Society and NJ Chapter,
American College of Chest Physicians*)

- 4 Breast Cancer
10:30 a.m.-12 noon—St. Mary's Hospital, Passaic
(*AMNJ*)
- 4 Medical Grand Rounds
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(*AMNJ*)
- 4 Monthly Dinner Meeting
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section, AMNJ*)
- 4 Anticipates In Office-Based Practice
9-11 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

- 4 Autoimmune Disease
11:30 a.m.-1 p.m.—Rahway Hospital
(*Rahway Hospital and AMNJ*)
- 4 Endocrine Conferences
- 11 3:30-5 p.m.—Rotates between Newark
- 18 Beth Israel Medical Center, College
- 25 Hospital, Newark and VA Medical Center, East Orange
(*AMNJ*)
- 4 Internal Medicine and Therapeutics
- 11 9-11 a.m.—Roosevelt Hospital, Menlo Park
- 18 (*Middlesex General Hospital and AMNJ*)
- 25 Sickle Cell Anemia
- 11 Medical Lecture Series
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 4 Medical Lecture Series
- 11 1-2:30 p.m.—VA Medical Center, Lyons
- 18 (*VA Medical Center and AMNJ*)
- 25 Pathogenesis of Diabetes Mellitus
- 4 Topic to be announced
- 11 Diabetic Complications
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 18 Medical Grand Rounds
9:30-11 a.m.—Newark Beth Israel Medical Center
(*AMNJ*)
- 5 Immunology '81
- 12 4-6 p.m.—Institute for Medical Research
- 19 Copewood St., Camden
- 26 (*Institute for Medical Research and AMNJ*)
- 6 Medical Grand Rounds
11:30 a.m.-1 p.m.—College Hospital, Newark
(*AMNJ*)
- 6 Renal Conferences in Nephrology
2-3:15 p.m.—College Hospital, Newark
(*Nephrology Society of NJ and AMNJ*)
- 7 Rehabilitation Following Stroke
8-10 a.m.—Newcomb Hospital, Vineland
(*Newcomb Hospital*)
- 10 Urinary Tract Infections
- 24 Hemo and Peritoneal Dialysis
12 noon-2 p.m.—West Jersey Hospital, Camden
(*West Jersey Hospital*)
- 10 Antibiotics for Everyday Use
8-10 p.m.—Schering Corporation, Kenilworth
(*NJ Dermatological Society and AMNJ*)
- 11 Neuroses in Office Practice
- 25 Clinical Approach to the Thyroid Nodule
9:30-11:30 a.m.—St. Clare's Hospital, Denville

(*Dover General, Riverside, and Saint Clare's Hospitals and AMNJ*)

- 11 Cardiology Conferences
- 25 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(*CMDNJ, Somerset County Heart Association and AMNJ*)
- 14 Angiotensin Receptors
4:30-5:30 p.m.—St. Barnabas Medical Center, Livingston
(*St. Barnabas Medical Center and AMNJ*)
- 16 Antibiotic Therapy
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson and AMNJ*)
- 18 Management of Hepatitis
11:30 a.m.—Columbus Hospital, Newark
(*AMNJ*)
- 18 Asbestos-Related Disease
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)
- 18 Gastrointestinal Fistulae
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 18 Dermatological Conference
6-8 p.m.—Rutgers Community Health Plan, 57 U.S. Highway #1 and Rt. 18, New Brunswick
(*CMDNJ and AMNJ*)
- 19 Problems in Occupational Health of Concern to Practicing Physicians
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
- 20 Myasthenia Gravis
12 noon-1 p.m.—Freehold Area Hospital
(*AMNJ*)
- 21 Clinical Endocrinology
9 a.m.-4 pm.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 23 Surgery in Treatment of Pancreatitis
7:45-9 a.m.—Newark Beth Israel Medical Center
(*Newark Beth Israel Medical Center and AMNJ*)
- 24 Topic to be announced
7:30-9 p.m.—Coachman Inn, Cranford
(*NJ Blood Club and AMNJ*)
- 25 Regional Hospital Meeting
8-10 p.m.—Holy Name Hospital, Teaneck
(*NJ Gastroenterological Society and AMNJ*)
- 25- Advanced Cardiac Life Support Course
- 26 9 a.m.-5 p.m.—NJ Medical School, Newark (*CMDNJ and AMNJ*)



The University of Pennsylvania School of Medicine Together with The Philadelphia Veterans Administration Medical Center

Present

"Nutrition In The '80s

Fifth Annual Nutrition Symposium

March 31, April 1, 2, 3, 1981

**Dunlop Auditorium
Medical Education Building
36th & Hamilton Walk
Philadelphia, PA 19104**

This course will provide the practicing physician, pharmacist, nurse, clinical nutritionist or hospital administrator with a physiologically-based clinical approach to common diagnostic and therapeutic problems in clinical nutrition. Practical aspects of nutrition support with maximum audience participation will be emphasized for maximum educational benefit.

Course Director:

James L. Mullen, M.D.

Chief, Surgical Service, Philadelphia VA
Medical Center

Director, Nutrition Support Service

Hospital of the University of Pennsylvania

Associate Professor of Surgery, University of
Pennsylvania School of Medicine

Application

Enrollment limited to 400

"Nutrition In The '80s

Fifth Annual Nutrition Symposium

March 31, April 1, 2, 3, 1981

NAME _____

ADDRESS _____

Make Check payable to University of Pennsylvania

Mail application to:

Office of Continuing Medical Education

School of Medicine G-3

University of Pennsylvania

Philadelphia, PA 19104

Registration Fee: \$75.00

Please Check:

M.D. R.N. R.D. R.Ph. Other

Academy of Medicine of New Jersey—Orthopaedic Section

The New Jersey Orthopaedic Society

CMDNJ-N.J. Medical School—Orthopaedic Division

St. Joseph's Hospital and Medical Center—Orthopaedic
Department

Present the

SIXTH ANNUAL N.J. ORTHOPAEDIC SYMPOSIUM

on
Friday & Saturday, March 27 & 28, 1981

at
**CMDNJ—Rutgers Medical School
Piscataway, N.J.**

The program will include presentations by nationally prominent speakers on cardiorespiratory management of patients with massive trauma, polytrauma management and external fixation; as well as abstract presentations by New Jersey orthopaedists.

The meeting will focus on the treatment of multiple trauma and the multiple injured patient.

For further information contact:

Linda Bartolo

Academy of Medicine of New Jersey

Two Princess Road

Lawrenceville, NJ 08648

Phone: (609) 896-1717

Academy of Medicine of New Jersey

The Radiological Society of New Jersey

The Society of Nuclear Medicine—Greater New York
Chapter

Present A Symposium On

NEW VISTAS IN NUCLEAR MEDICINE

Sheraton Inn—Newark Airport

Route #1, Elizabeth, New Jersey

Saturday, April 4, 1981 8:55 A.M.—3:20 P.M.

The program will include presentations by nationally prominent speakers on pediatric nuclear medicine; hepato biliary scanning and correlation with ultrasound; cardiac nuclear medicine; and intra-abdominal imaging and correlation to ultrasound and body CT.

For Further Information Contact:

Linda Bartolo

Academy of Medicine of New Jersey

Two Princess Road

Lawrenceville, New Jersey 08648

Phone: (609) 896-1717

- 26 Oncologic Emergencies**
1-2:30 p.m.—Englewood Hospital
(*Englewood Hospital Cancer Committee and AMNJ*)
- Apr.**
- 1 Topic to be announced**
2 p.m.—St. Elizabeth Hospital, Elizabeth
(*NJ Society for Gastrointestinal Endoscopy and AMNJ*)
- 1 Speech and Hearing Seminar**
8 a.m.-3:30 p.m.—J.F. Kennedy Medical Center, Edison
(*J.F. Kennedy Medical Center, Robert Wood Johnson Rehabilitation Institute and AMNJ*)
- 1 Allergy**
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 1 Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section, AMNJ*)
- 1 Medical Grand Rounds**
11:30 a.m.-1:00 p.m.—VA Medical Center, East Orange
(*Endocrinology Section, AMNJ*)
- 1 Anemia**
9 a.m.-11 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
- 1 Use of Antibiotics in the Elderly**
- 15 Contemporary Use of Anticoagulants**
- 29 Carbon monoxide-Impact of Auto Emissions**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 1 Internal Medicine and Therapeutics**
8 9-11 a.m.—Roosevelt Hospital, Menlo Park
15
22 (*Middlesex General Hospital and AMNJ*)
- 29 Endocrine Conferences**
8 3:30-5 p.m.—Rotates between Newark
15 Beth Israel Medical Center, College
22 Hospital, Newark and VA Medical
29 Center, East Orange
(*Endocrinology Section, AMNJ*)
- 1 Medical Lecture Series**
8 1-2:30 p.m.—VA Medical Center, Lyons
15 (*VA Medical Center and AMNJ*)
- 22**
- 1 Medical Lecture Series**
8 1-3 p.m.—Christ Hospital, Jersey City
15 (*Christ Hospital and AMNJ*)
- 22**
- 29**
- 2 Immunology '81**
9 4-6 p.m.—Institute for Medical Research
23 Copewood St., Camden
30 (*Institute for Medical Research and AMNJ*)
- 2 Medical Grand Rounds**
9:30-11 a.m.—Newark Beth Israel Medical Center
(*Endocrinology Section, AMNJ*)
- 3 Medical Grand Rounds**
11:30 a.m.-1:00 p.m.—College Hospital, Newark
(*Endocrinology Section, AMNJ*)
- 3 Renal Conferences in Nephrology**
17 2-3:15 p.m.—College Hospital, Newark
(*Nephrology Society of NJ and AMNJ*)
- 3 Inflammatory Arthritis**
8 p.m.—Burdette-Tomlin Memorial Hospital, Cape May
(*AMNJ*)
- 7 Colon-Rectal Cancer**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 7 Hypertension in the Elderly**
- 14 Steroidal vs. Nonsteroidal Rx in Arthritis**
- 28 Acid Base Balance and Electrolyte Disorders**
8-9 a.m.—Greater Paterson General Hospital, Wayne
(*Greater Paterson General Hospital and AMNJ*)
- 8 Vector-Borne Diseases of Man and Animal**
9:45 a.m.-3 p.m.—Sheraton Inn, New Brunswick
(*NJ Public Health Association and AMNJ*)
- 8 Diagnosis and Treatment of Diabetes, Including Oral Antidiabetics**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(*Dover General, Riverside and Saint Clare's Hospitals and AMNJ*)
- Immunologic Mechanism of Renal Disease**
- 8 11:30 a.m.-1 p.m.—VA Medical Center, East Orange**
- 8 6-10 p.m.—Holiday Inn, East Orange**
- 9 9:30-10:30 a.m.—Newark Beth Israel Medical Center**
(*The Nephrology Society of NJ and AMNJ*)
- 8 Cardiology Conferences**
- 22 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick**
(*Rutgers Medical School, Somerset County Heart Association and AMNJ*)
- 8- Vertigo: Diagnosis and Practical**
- 9 Application of Electronystagmography**
8 a.m.-6 p.m.—499 Broad Street, Shrewsbury
(*Otologic Education, Inc. and AMNJ*)
- 10 The Role of Prostaglandins and Kinins in Human Hypertension**
4:30-5:30 p.m.—St. Barnabas Medical Center, Livingston
(*St. Barnabas Medical Center and AMNJ*)
- 11 Pheochromocytoma**
8-10 a.m.—Newcomb Hospital, Vineland
(*Newcomb Hospital*)
- 14 Psycocutaneous Disorders**
8 p.m.—Schering Corporation, Kenilworth
(*NJ Dermatological Society and AMNJ*)
- 14 Prophylactic Antibiotics**
- 28 Management of Arrhythmias**
12 noon-2 p.m.—West Jersey Hospital, Camden
(*West Jersey Hospital*)
- 15 Physicians' Role in Drug Abuse**
8:30-4:30 p.m.—Rutgers Medical School, Piscataway
(*AMNJ*)
- 15 The Value of Screening for Lung Cancer**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)
- 15 Immunology (Clinical)**
11:30 a.m.—Columbus Hospital, Newark
(*AMNJ*)
- 15 Dermatological Conference**
6-8 p.m.—Rutgers Community Health Plan, 57 U.S. Highway #1 and Rt. 18, New Brunswick
(*CMDNJ and AMNJ*)
- 16 Graduate Teaching Program**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
- 20 Advances in Insulin-Dependent Diabetes Mellitus**
12 noon-1 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)
- 20 Radiological Evaluation of Mediastinal Masses**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 21 Infectious Disease**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 24 Adrenal Diseases**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 25 Hemodialysis, Peritoneal Dialysis and Ultrafiltration in Management of Renal Failure**
8-10 a.m.—Newcomb Hospital, Vineland
(*Newcomb Hospital*)
- 29- Advanced Cardiac Life Support Course**
- 30 9 a.m.-5 p.m.—NJ Medical School, Newark (CMDNJ and AMNJ)**
- NEUROLOGY/PSYCHIATRY**
- Mar.**
- 2 Add Self to Wife and Mother**
8-10 p.m.—111 Ridgewood Ave., Glen Ridge
(*Essex Psychiatric Doctors Seminars and AMNJ*)
- 2 Neuroscience Conferences**
9 11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
16 (*Bergen Pines County Hospital and AMNJ*)
- 23 Psychiatric Case Conferences**
3 7:30-9:30 a.m.—Trenton Psychiatric Hospital
10
17 (*Trenton Psychiatric Hospital and AMNJ*)
- 24 Personality Traits Leading to Cult Readiness**
- 18 Movement Disorders**
1:30-3 p.m.—Community Mental Health Center—NJ Medical School
(*CMDNJ and AMNJ*)
- 4 Treatment of Different Populations of Drug Abuse**
- 11 Psychosomatic Medicine**
- 25 The Nuclear Family in Crisis**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 4 Staff Burn-Out Syndrome**
- 11 Pseudo seizure and Its Differential Diagnosis**
18 1-2:30 p.m.—VA Medical Center, Lyons
25 (*VA Medical Center and AMNJ*)
- 4 Ongoing Child Psychiatry Case Conference and Lecture**
8:30-10:30 a.m.—Trenton Psych. Hosp.

RECENT PROGRESS IN CLINICAL ENDOCRINOLOGY

March 21, 1981

**College of Medicine & Dentistry of New
Jersey-New Jersey Medical School,
Newark, N.J.**

Category I credit offered. A.O.A. accredited. A.A.F.P. applied for.

Objective: This course is intended to aid physicians practicing general internal medicine and/or endocrinology in keeping abreast of the major recent advances in the fields of endocrinology and metabolic medicine. Adequate background will be provided for those physicians who are not currently in an academic environment.

Registration fee: \$60.

For further information please contact:

Patricia Sarles, M.S.
CMDNJ-Office of Continuing Education
100 Bergen Street
Newark, N.J.
(201) 456-4267



THE COLLEGE OF PHYSICIANS & SURGEONS OF COLUMBIA UNIVERSITY

Postgraduate medicine courses for Spring, 1981:

Postgraduate Review Course in Functional Neuroanatomy and Neurophysiology, January 10-April 4, 1981 (13 Saturdays, 9:30-Noon). Fee: \$260; Resident's fee: \$130. (26 credit hours). Edgar M. Housepian, M.D.

Ophthalmology Saturday Continuing Medical Education Program, Five Saturdays, 9 am-4:30 pm: **A. Dec. 6, 1980: What Every Physician Should Know About Eye Disease;** **B. Jan. 10, 1981: Cornea And External Disease;** **C. Feb. 7, 1981: Ocular and Adnexal Trauma;** **D. Mar. 7, 1981: Ocular Therapeutics and E. April 4, 1981: Topics in Pediatric Ophthalmology.** Fee: \$85; Resident's fee: \$20. (7 credit hours per session). R. Linsy Farris, M.D.

Internal Medicine Review Course, January 5-June 22, 1981 (25 Mondays, 5:30-7:30 pm). Fee: \$300; Resident's Fee: \$150. (50 credit hours). Department of Medicine.

Hypnosis and Psychiatry, March 23-26, 1981 (Monday-Thursday). Fee: \$400; Resident's fee: \$300 (includes workshops and lunches). (32 credit hours). Herbert Spiegel, M.D.

Specialty Pathology of the Head and Neck, March 30-April 3, 1981 (Monday-Friday): **March 30: Skin;** **March 31: Oral Cavity;** **April 1: Nerve and Muscle;** **April 2: Neoplasia of Central Nervous System and Eye;** **April 3: Demyelinating, Metabolic, and Degenerative Diseases of the Central Nervous System.** Fee: \$400 or \$100 each day; residents: \$200 or \$50 each day. (fee includes syllabus and luncheons). (30 credit hours). Donald W. King, M.D.

Cutaneous Vulvar and Vaginal Diseases, May 14-16, 1981 (Thursday-Saturday). Fee: \$375; Resident's fee: \$175 (in-

cludes syllabus and lunches). (18 credit hours, 18 cognates by A.C.O.G., and 18 Prescribed Hours from the A.A.F.P.). Alex W. Young, M.D. and Harold M.M. Tovell, M.D.

Current Concepts in Liver Pathology, Second Annual Course, Histopathology Slide Seminar and Short Course. May 22-23, 1981 (Friday-Saturday). Fee: \$225; Resident's fee: \$120 (fee includes syllabus, set of 60 Kodachrome slides and luncheons). (13 credit hours). Jay Lefkowitz, M.D.

Experimental Therapeutics of Movement Disorders. May 26-27, 1981 (Tuesday-Wednesday). **CALL FOR PAPERS:** Papers are now being accepted for this symposium. The deadline for submission of abstracts is February 27, 1981. Regarding submission of papers, contact: Dr. Stanley Fahn, Neurological Institute, 710 168th Street, New York, NY 10032. Fee: \$200; Resident's: \$100 (fee includes a syllabus and lunches). (14 credit hours). Stanley Fahn, M.D.

The Growing Child: Common Problems in Growth and Development. May 27-29, 1981 (Wednesday-Friday). Fee: \$200; Resident's fee: \$100 (includes lunches and syllabus). (18 credit hours). Drs. Michael Katz and Stephen J. Atwood.

Names of Course Directors follow each listing. All courses approved for Category 1 credit of the A.M.A.'s P.R.A. Contact: DR. ELIZABETH C. GERST, Continuing Education Center, P&S, 630 W. 168th St., N.Y., N.Y. 10032; telephone: (212) 694-3682.

(Trenton Psychiatric Hospital and AMNJ)		24	Immunology 11 a.m.—Greystone Park Psychiatric Hospital (AMNJ)	9:30-11 a.m.—Bergen Pines County Hospital, Paramus (Bergen Pines County Hospital and AMNJ)	
5	Brief Psychotherapy Techniques				
12	Case Presentation				
19	Family Therapy for the Treatment of Children	25	Role of General Practitioner in Psychiatry 1-3 p.m.—Christ Hospital, Jersey City (Christ Hospital and AMNJ)	8	Outpatient Psychotherapy of Psychotic Adolescents
26	Family Therapy for the Treatment of Adolescents 11 a.m.-12 noon—Greystone Park Psychiatric Hospital (Greystone Park Psychiatric Hospital and AMNJ)			22	Diagnosis and Treatment of Hysteria 1-3 p.m.—Ancora Psychiatric Hospital, Hammonton (Ancora Psychiatric Hospital and AMNJ)
5	Encouraging Adherence to Medical Regimes	Apr.		15	Slow Virus Infection of the Nervous System 1-2:30 p.m.—VA Medical Center, Lyons (VA Medical Center and AMNJ)
12	Behavioral Modification of Borderline Disorders	1	Child Psychiatry Case Conference	15	Psychiatric Emergencies 1:30 p.m.—Trenton Psychiatric Hospital (AMNJ)
26	Movement Disorders Update 12 noon-1 p.m.—Carrier Foundation, Belle Mead (Carrier Foundation and AMNJ)	8	8:30-10:30 a.m.—Trenton Psychiatric Hospital	15	A Lecture in Law and Psychiatry
6	Psychiatric Lecture 1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)	22	(Trenton Psychiatric Hospital and AMNJ)	29	Ethnicity and the New Immigrant in America 1:30-3 p.m.—NJ Medical School, Newark (CMDNJ and AMNJ)
6	DSM: Practical Review	2	Family Therapy for Treatment of Adults	16	Working with Parents of Adolescents with Alcohol and/or Drug Addiction Problems 12 noon-1 p.m.—Carrier Foundation, Belle Mead (Carrier Foundation and AMNJ)
13	Differential Diagnosis of Fugue-Like States	9	Case Presentation	22	Transient Cerebral Ischemic Attacks 9:30-11 a.m.—Bergen Pines County Hospital, Paramus (Bergen Pines County Hospital and AMNJ)
27	Differentiating Manic-Depressive Illness and Schizophrenia 12 noon-1:30 p.m.—Carrier Foundation, Belle Mead (Carrier Foundation and AMNJ)	16	Organic Brain Syndrome in the Geriatric Population		
6	Psychological Testing and Basics of Statistics	23	Geriatric Population		
13	Statistics	30	11 a.m.-12 noon—Greystone Park Psychiatric Hospital (Greystone Park Psychiatric Hospital and AMNJ)		
20	2:45-3:45 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)	2	Borderline Syndrome		
6	Neuroanatomy/Neuropathology and Clinical Neurology	9	Masked Depression		
13	Clinical Neurology	23	Agoraphobia		
20	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)	30	Misdiagnosis of Schizophrenia 12 noon-1 p.m.—Carrier Foundation, Belle Mead (Carrier Foundation and AMNJ)		
27	Hospital	3	Neuroanatomy/Neuropathology and Clinical Neurology		
6	Community Psychiatry	10	Neuroanatomy/Neuropathology and Clinical Neurology		
13	1:30-2:30 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)	24	Medical Ethics 4-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)		
20	Hospital	3	Psychosocial Factors in Influencing Schizophrenia		
27	(Trenton Psychiatric Hospital and AMNJ)	10	Genetics and Counseling in Psychiatric Illness		
6	Psychiatric Lecture	24	Pathologic Grief and Anniversary Reactions 12 noon-1:30 p.m.—Carrier Foundation, Belle Mead (Carrier Foundation and AMNJ)		
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)	3	Community Psychiatry		
20	Hospital	10	Community Psychiatry		
27	(Trenton Psychiatric Hospital and AMNJ)	24	Administrative Psychiatry 1:30-2:30 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)		
6	Psychiatric Lecture	3	Psychological Testing and Basics of Statistics		
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)	10	Genetics and Psychiatry		
20	Hospital	24	Genetics and Psychiatry 2:45-3:45 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)		
27	(Trenton Psychiatric Hospital and AMNJ)	6	Neuroscience Conference		
6	Psychiatric Lecture	13	11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus (Bergen Pines County Hospital and AMNJ)		
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)	20	County Hospital, Paramus		
20	Hospital	27	(Bergen Pines County Hospital and AMNJ)		
27	(Trenton Psychiatric Hospital and AMNJ)	6	Regression in an Adolescent Girl Following Divorce 8-10 p.m.—60 Melrose Place, Montclair (Essex Psychiatric Doctors Seminars and AMNJ)		
6	Psychiatric Lecture	7	Psychiatric Case Conference		
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)	14	7:30-9:30 a.m.—Trenton Psychiatric Hospital		
20	Hospital	21	Hospital		
27	(Trenton Psychiatric Hospital and AMNJ)	28	(Trenton Psychiatric Hospital and AMNJ)		
6	Psychiatric Lecture	8	Treatable Dementias		
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric Lecture				
13	1:30-5 p.m.—Trenton Psychiatric Hospital (Trenton Psychiatric Hospital and AMNJ)				
20	Hospital				
27	(Trenton Psychiatric Hospital and AMNJ)				
6	Psychiatric				

PATHOLOGY

Mar.

- 16 Nephrotic Syndrome
12 noon-1 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)
- 20 I.V. Isuprel in the Treatment of Children
7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
- 24 Cytologic Diagnosis by Fine-Needle Aspiration
8 p.m.—Warren Hospital, Phillipsburg
(*AMNJ*)

PEDIATRICS

Apr.

- 1 Life-Threatening Pediatric Disease
11:30 a.m.—Rahway Hospital
(*AMNJ*)
- 17 Chronic Diarrhea in Children
7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

RADIOLOGY

Mar.

- 11 Case Presentation
7:45-10:15 p.m.—Morristown Memorial Hospital
(*Radiological Society of N.J.*)
- 12 Home Talent—Obstetrics
7:30-9:30—p.m.—St. Barnabas Medical Center, Livingston
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 17 Radionuclide Myocardial Imaging
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 18 Dinner Meeting
6:30 p.m.—The Manor, West Orange
(*Radiotherapy Section, AMNJ*)
- 19 Visiting Professorship Program
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(*St. Barnabas Medical Center*)
- 19 Radiology of Soft Tissues
8 p.m.—Hospital Center at Orange
(*Radiological Society of NJ and AMNJ*)

Apr.

- 4 Nuclear Medicine
8:30 a.m.—5 p.m.—Sheraton Inn, Newark Airport
(*AMNJ*)
- 4 Basic Echocardiography
5 9 a.m.-5 p.m.—Nassau Inn, Princeton
(*National Foundation for Non-Invasive Diagnostics and AMNJ*)
- 8 Ultrasound

2 p.m.—John E. Runnells Hospital, Berkeley Heights
(*AMNJ*)

- 8 Neuro-Radiology Meeting
7:45-10:15 p.m.—Morristown Memorial Hospital
(*Radiological Society of NJ and AMNJ*)
- 9 Obstetrics
7:30-9:30 p.m.—St. Barnabas Medical Center, Livingston
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 16 Bone Disease
8 p.m.—Hospital Center at Orange
(*Radiological Society of NJ and AMNJ*)
- 16 Nuclear Cardiology
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
- 21 Radiologic Aspects of Diseases of the Appendix
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 23 Visiting Professorship Program
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(*St. Barnabas Medical Center*)
- 28 CT Scan: Other than the Head Region
8 p.m.—Warren Hospital, Phillipsburg
(*AMNJ*)
- 29 Interventional Radiology
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)

GENERAL SURGERY

Mar.

- 3 Tumor Conferences
- 10 12 noon—Morristown Memorial
- 17 Hospital
- 24 (*Morristown Memorial Hospital and AMNJ*)
- 11 Staplers in Thoracic Surgery
8-10 p.m.—Canoe Brook Country Club, Summit
(*NJ Society of Thoracic Surgeons and AMNJ*)
- 12 Tumor Conference
12 noon-1 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 19 Diverticulitis
7:30-9 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
- 24 Thyroid Biopsies
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 25 Energy Metabolism
9:30-1 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines Co. Hospital and AMNJ*)

Sixth Annual Orthopaedic Symposium

- 27 12 noon-4 p.m.—Rutgers Medical School, Piscataway
- 28 8 a.m.-4 p.m.—same location
(*NJ Orthopaedic Society and AMNJ*)

Apr.

- 7 Tumor Conferences
- 14 12 noon-1 p.m.—Morristown Memorial
- 21 Hospital
- 28 (*Morristown Memorial Hospital and AMNJ*)
- 8 Cardiac Surgery
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 9 Tumor Conference
12 noon-1 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 16 Cancer of the Esophagus
7:30-9 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
- 29 Pediatric Surgery
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastic, and Vascular Surgery)

Mar.

- 18 Joint Replacements
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- Sixth Annual Orthopaedic Symposium
- 27 12 noon-4 p.m.—Rutgers Medical School
- 28 8 a.m.-4 p.m.—Rutgers Medical School, Piscataway
(*NJ Orthopaedic Society and AMNJ*)

Apr.

- 7 Mesenteric Vascular Disease—Colon
5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)
- 21 Heart Valve Replacement
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)

MISCELLANEOUS

Apr.

- 7 Hospital Dentistry
9:30-3:30 p.m.—NJ Medical School, Newark
(*Dental Section, AMNJ*)
- 15 Current Malpractice Update
11 a.m.—South Bergen Hospital, Hasbrouck Heights
(*AMNJ*)

Dr. R. Grant Barry

One of Mercer County's senior members, R. Grant Barry, M.D., died on December 19, 1980 at Helene Fuld Medical Center, Trenton. A native of Rochester, New York, Dr. Barry was graduated from Jefferson Medical College in 1912 and pursued a career in psychiatry, becoming board certified in psychiatry and neurology. He had been associated with the New Jersey State Hospital in Trenton and the Glenwood Sanatorium, and in more recent years had been in private practice in Trenton, retiring in 1972. Dr. Barry was a former medical director of the Trenton public school system and had been on the staff of both Mercer and St. Francis Hospitals in Trenton. In 1962 he was a recipient of MSNJ's Golden Merit Award in recognition of his fifty years of practice. Dr. Barry was 94 years old at the time of his death.

Dr. Joseph Binder

A member of our Monmouth County component, Joseph Binder, M.D., of Long Branch, died on October 10, 1980. A graduate of Long Island University College of Medicine, class of 1930, Dr. Binder was a family practitioner for many years and had been affiliated with Monmouth Medical Center in Long Branch. He was 74 years old at the time of his death. Dr. Binder was a 1980 recipient of MSNJ's Golden Merit Award indicating 50 years as a physician.

Dr. A. James Fessler

A. James Fessler, M.D., a well-known Trenton surgeon and member of the Mercer County Medical Society, beloved by colleagues and patients alike, died on December 13, 1980 at Helene Fuld Medical Center (Trenton) where he had been associated all of his pro-

fessional career. A native of Pennsylvania, Dr. Fessler taught at the high school level and was director of physical culture for the YMCAs of Western Pennsylvania before matriculating at Hahnemann Medical College where he earned his medical degree in 1925. He came to Trenton in 1926 to establish a general and obstetric practice while pursuing graduate studies in surgery, completing these in 1933. At Helene Fuld he had been chief of staff, medical director, chief of the surgery section, and held lifetime memberships on the board of trustees and the board of governors. He was a Fellow of the International College of Surgeons and of the American Society of Abdominal Surgeons. A son, A. James Fessler, Jr., who had been associated with his father in practice, is a Trenton surgeon. In 1975 Dr. Fessler received MSNJ's Golden Merit Award honoring his fifty years in medicine, and in 1976 he was honored at a testimonial for having served Helene Fuld Medical Center for 50 years.

Dr. James E. Stuart

On December 7, 1980, James Earle Stuart, M.D., died at his home after a long illness. A well-known Plainfield physician, Dr. Stuart was born in York, Pennsylvania in 1894 and earned his medical degree from Howard University Medical College in 1925. After internship in Kansas City General Hospital, he came to Plainfield to establish a family practice (later to specialize in the treatment of chest diseases), while pursuing graduate education at Columbia University, leading to a masters degree in public health, and studies in chest diseases at the University of Pennsylvania in Philadelphia and Bellevue Hospital in New York. He was a member of the attending staff at the John E. Runnells Hospital for Chest Diseases in Berkeley Heights for 30 years, retiring in 1964, and had served as secretary of the

medical staff for a long period. Dr. Stuart was affiliated also with the Muhlenberg Hospital in Plainfield, and had served as a public health physician with the New Jersey State Department of Health. He was active in civic affairs and had been a member of the Plainfield Housing Authority for many years, accepting its presidency in 1967. In 1975, Dr. Stuart was a recipient of MSNJ's Golden Merit Award indicating fifty years as a physician.

Dr. Joseph F. Videtti

On December 13, 1980, Joseph F. Videtti, M.D., a member of our Bergen County component, and former physician for the Fairview public school system, died at his home. Born in 1902 and graduated from Yale University Medical College in 1927, Dr. Videtti was a family practitioner in Fairview and had been on the staff at Christ Hospital in Jersey City and Holy Name Hospital in Teaneck. Dr. Videtti was a 1977 recipient of MSNJ's Golden Merit Award marking the fiftieth anniversary of his practice of medicine.

Dr. Levi M. Walker

One of Atlantic County's senior members, Levi Moore Walker, M.D., died on October 30, 1980, in St. Croix, VI, where he had been living in retirement. A native of McKeesport, Pennsylvania, born at the turn of the century, Dr. Walker was a graduate of the University of Pittsburgh, class of 1926 and established an office in Atlantic City to pursue a career in internal medicine, with special emphasis on cardiology. He had been chief of the medical service at the Atlantic City Medical Center and attending cardiologist at the Shore Memorial Hospital in Somers Point. During World War II, Dr. Walker served with the Department of Medicine of the AUS.

General Ophthalmology, 9th Ed.

Daniel Vaughan, M.D. and Taylor Asbury, M.D. Los Altos, California, Lange, 1980. Illustrated. Pp. 410. (\$15)

This latest edition of a very popular text and reference book directed toward medical students, general physicians and beginning ophthalmology residents is some 30 pages longer than the preceding edition of 1977, and has been reset in a larger, blacker and more readable type.

There have been some minor changes in the contents and a rearrangement of the chapters. The only chapter to be substantially revised and enlarged is the one on the cornea, which was contributed by Dr. Phillips Thygeson.

This new volume is, as were the previous editions, a comprehensive and up-to-date text that can be recommended highly for all physicians as a handy source of knowledge on ophthalmology essential to good practice of medicine.

Arthur S. Kern, M.D.

Weeping May Tarry: My Long Night with Cancer

Hazel Lin, M.D., Boston, Branden Press, 1980. Pp. 51. (No price given)

In a brief, unpretentious diary Hazel Lin, gynecologist and surgeon, writes about her own successful fight with cancer (follicular lymphosarcoma). On December 22, 1977, she is given the stamp "NED," no evidence of disease, an occasion she celebrated by making the last entry in her journal.

She has no vocabulary, says Dr. Lin, to describe what she feels on contemplating her own death. Words do indeed fail her on occasion, as they would anyone other than perhaps a great poet or a writer. But both her ordeal and her personality come through: terror, pain, shock, loss, morbid fantasies succeed

one another to be alleviated by courage, love, loyalty, altruism. Recollections of a life well spent seem to be a major source of strength. Dr. Lin is a deeply religious person and describes, as well, a comforting mystical experience.

She also addresses the fear of dying, of morbidity, of progressive disability. It is particularly poignant that the patient is a physician; helpful self-delusion is harder to come by for one who understands so well the process of disease. The author describes the humiliations and dehumanization of becoming a patient. But she acknowledges also the competence and generosity of many colleagues, physicians and nurses.

No mortal has ever seen the real face of death, says Dr. Lin, echoing the plaint of many others before her.

But death is the inevitable outcome of life.¹ Death is natural. It is still always an outrage to human consciousness. The knowledge of having lived a worthwhile life best mitigates the pain of death.

The main value of Dr. Lin's book, apart from its cathartic effect for the author, lies in the generous sharing of the details of the confrontation with death which should help readers contemplate with greater equanimity the universality and inevitability of death.

Edith T. Shapiro, M.D.

Prisoners of Pain

Arthur Janov. New York, Anchor/Doubleday, 1980. pp. 276 (\$11.95)

The author has produced yet another of the many works testifying to the superiority of a particular technique of psychological treatment, namely *primal therapy*. This sixth publication, subtitled, *Unlocking the Power of the Mind to End Suffering*, promotes the virtues of experiencing *primal pain*. *Primal pain* is a reaction to the frustration of basic needs, blocked from realization and expression at an early age. His major thesis is that the repression of emotional expression accompanying feeling hurt (including birth trauma) constitutes the

basic difficulty underlying neurosis and psychosis. Scores of patients are quoted on the dramatic beneficial effects of venting these intense reactions to memories of the past relived vividly in the primal therapy session.

There is no doubt that the crucial turning point in some patients may be the profound reexperiencing of earlier traumatic events. My skepticism is aroused by his implications that he can help a wide spectrum of sufferers. He does not discuss diagnostic considerations, indications, contraindications, the dangers of such regressive trips for borderline and schizophrenic patients and so on. He emphasizes a cathartic release of memories and feelings to the exclusion of other important elements, such as the doctor-patient relationship and a shared belief system. The reader might mistakenly infer that primal therapy is a panacea, and that all other treatments are merely palliative. The author relates brain and mind hypotheses and findings to his work in a persuasive manner, yet fails to convince this reviewer of his scientific proofs.

Leonard Hollander, M.D.

The Human Patient.

Naomi Remen, M.D., New York, Anchor/Doubleday, 1980. Pp. 238. (\$10.95)

This is a book for practicing physicians, and those who want to be. Its main theme is that the doctor see the patient with a disease rather than looking only at the disease itself. It begins with the premise that the human patient needs something more than technology, and ends with an appeal for the physician to be a whole person; it urges a willingness to drop the facade of professionalism and show the human side of caring (much of which is "applied common sense"). In between, it discusses the "different styles of interaction around health issues—from the authoritarian role in emergencies to the collaborative role in prevention." Throughout the book are many interesting examples of

¹Fries James F: Aging, natural death and the compression of morbidity. *N Engl J Med*, (July 17) 1980.

physician-patient interchange and conflict.

Since "disease, like all other known experiences, is part of a lifelong process of learning and growth," it is suggested that there may be more healthy ways for patients to look at disease and learn from the experience, and possibly see a meaning for their illness and a larger meaning for their life.

The chapter on "Free Choice" urges that patients be supported "in choosing freely how they live their life, no matter how short that life may be." Faced with illness or pain, a patient "can choose to regard it as a disaster, or as an opportunity for learning." And the doctor, being in "a front row seat in the theater of life," has "an unparalleled opportunity to learn about and deeply understand human nature."

This is a thoughtful book filled with some newer perspectives on the interaction between physician and patient.

John S. Madara, M.D.

A Good Idea: An Introduction to the Nutrition Foundation.

The National Advisory Committee on Hyperkinesia and Food Additives. New York, The Nutrition Foundation, 1980. (No price given.)

This report should be read by all physicians who provide care for the heterogeneous group of children and adolescents who are said to have the "Attention Deficit Disorder" or "Minimal Brain Dysfunction" or the "Hyperkinetic Behavior Disorder" or one of the many other labels utilized for patients with varying combinations of problems with learning and behavior at home or at school.

The eminent members of a select committee carefully have reviewed the literature including the recent studies prompted by claims that special diets are of therapeutic value for the children who have difficulty in learning or in behavior. After a careful analysis of available information the committee concludes:

"The studies already completed provide sufficient evidence to refute the claim that artificial food colorings, artificial flavorings and salicylates produce hyperactivity and/or learning disability . . . there is a general need to remain vigilant regarding the safety of food colors but this issue should stand

on its own merits . . .

"Since the food-additive-free diet has no apparent harmful effects, and since the non-specific (placebo) effects of this dietary treatment are frequently very beneficial to families, we see no reason to discourage . . ."

Regrettably, the study makes a number of additional statements about public policy on labeling, further research, and the use of federal funds, which are not warranted by the evidence presented, and which, in light of the fact that the Nutrition Foundation of the National Advisory Committee on Hyperkinesia and Food Additives is financed by corporations from the food industry, leaves the reader with just that bit of insecurity about the entire report so that it is hard to endorse it to patients with complete ease.

Avrum L. Katcher M.D.

Sound Sleep

Quentin R. Regestein, M.D. with James R. Rechs. New York, Simon and Schuster, 1980. Pp. 208. (\$10.95)

Amid the rash of books written by physicians for lay consumption, it is rare to find one of quality. Happily, Dr. Quentin R. Regestein's book, "Sound Sleep," has avoided the obvious pitfalls and should make a significant contribution to the comfort of many of us who are plagued by insomnia. Dr. Regestein, who is the Director of the Sleep Clinic at Harvard's Peter Bent Brigham Hospital, has written a book which is both firmly based in clinical research and easily understandable. The style of presentation is provocative without being condescending. Dr. Regestein avoids making promises of a miraculous cure, emphasizing throughout that nothing of significance will occur without the reader's active involvement in modifying many behaviors which tend to interfere with sound sleep.

Following a brief definition of insomnia, the author devotes a single well-written chapter to a presentation of recent finding relating to how and why we sleep. Other chapters are devoted to the effects of hyperarousal and anxiety and how to lower their levels; the importance of an ordered life style, the effects of common stimulants such as coffee and tea; the relationship of depression to insomnia; the hazards of sleeping pills and sleep difficulties in the elderly. Many of the chapters conclude with a

self-assessment questionnaire, along with a scoring key.

Finally, in an appendix, Dr. Regestein presents a directory of Sleep Clinics, where readers with problems which do not prove amenable to his common-sense approach can seek professional assistance. Physicians from every specialty should find this a useful book to recommend to their many patients who suffer from sleeplessness. In fact, most physicians will find much to value if they take the time to read this brief, easily digested volume.

Irwin W. Pollack, M.D.

Mesmerism: A Translation of the Original Medical and Scientific Writings of F.A. Mesmer, M.D.

Translation by George Bloch, Ph.D., Los Altos, CA, William Kaufman, 1980. (\$11.50)

It is quite possible that no single individual in the long history of medicine managed to arouse more controversy than did Franz Anton Mesmer (1734-1815). His theory of animal magnetism later called mesmerism was denounced by the savants of the French Academy of Medicine with the approval of our own Benjamin Franklin, then Ambassador to France. But many perceptive physicians believed that, beneath all the hocus-pocus and garish theatricality that surrounded his laying on of hands, there existed a substratum of truth and he was ardently supported by philosophers as well as mystics in the German-speaking community. No one seriously would deny today that mesmerism laid the foundation for our present knowledge of hypnotic influence as a therapeutic measure.

Now for the first time we are presented with an adequate English version of the significant writings of Mesmer, and interested readers can try for themselves to separate the kernel of wheat from the florid prose which envelopes the chaff. Mesmer insisted that the "sixth sense" with which he felt himself endowed could not be transmitted to scoffers, and he insisted on divulging these arcane principles only to highly-motivated adepts. All students of psychology and psychiatry should be grateful to Dr. George Bloch for making this translation available.

Morris H. Saffron, M.D.

NEEMA EMERGENCY MEDICAL —a professional association—

Emergency Medicine Positions—available with emergency physician group in Pa., N.Y., N.J., Va., W. Va., Md. and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical
Suite 400
399 Market Street
Philadelphia, Pa. 19106

or phone
in Pa., (215) 925-3511
outside Pa., 800-523-0776

SEEKING OBSTETRICIAN and ANESTHESIOLOGIST

Lovely southwestern climate. Multispecialty group seeking Obstetrician-Gynecologist and an Anesthesiologist. Substantial guarantee. Contact Talton L. Francis, El Paso Medical-Surgical Associates, Pa., 10301 Gateway West, El Paso, Texas 79925.

LOOKING FOR PROPERTY IN A SPANISH- SPEAKING AREA?

FOR SALE—Building suitable for medical group practice in Spanish-speaking area of Lakewood, N.J. Occupied apartments cover operating costs. Very reasonable.

Contact
Genia Berk

SPECIALIZING IN MEDICAL/DENTAL PROFESSIONAL
AND INVESTMENT PROPERTIES
FOR

STERLING THOMPSON AND ASSOCIATES

1250 Highway 35, P.O. Box 667
Middletown, N.J. 07748

Tel. (201) 671-6300 • 800-392-6810

FOR SALE

- Ideal parcel for a Medical Center
- You can choose from 4 to 7 acres
- Next to a Nursing Home
- Approximately one mile from the proposed St. Vincent's Hospital
- On Passaic Avenue in West Caldwell, N.J.
- Near Bloomfield Avenue, convenient to Routes 80, 280 and Eisenhower Parkway
- Call John Valentine for a copy of our detailed flyer (201) 857-2800



**VALENTINE
ASSOCIATES, INC.**
REALTORS

80 POMPTON AVENUE
VERONA, NEW JERSEY 07044

(201) 857-2800

NEW JERSEY—ANCORA

Immediate openings for New Jersey licensed Staff Psychiatrists in 1000 bed JCAH and AMA Accredited Psychiatric Hospital. Affiliated with Temple University Hospital, Department of Psychiatry. Located 30 miles from Atlantic City and Philadelphia. Salary commensurate with training and experience from \$33,885 to \$50,435. Private practice after duty permitted. Liberal fringe benefits include Blue Cross, Blue Shield, and Life Insurance.

Write: Engracio Balita, M.D., Medical Director
Ancora Psychiatric Hospital
Box B
Hammonton, New Jersey 08037
or call
(609) 561-1700, Ext. 203

INDUSTRIAL/EMERGENCY PHYSICIAN

We are seeking a physician to augment our staff in our Trenton industrial clinic. Opportunity for advancement. Salary competitive, merit increments. Excellent benefits include malpractice and CME allowance. No night or weekend duty. New Jersey license required. Send salary requirements and curriculum vitae to Box No. 225, c/o JOURNAL MSNJ.

NEED AN OFFICE LOCATION?

Why not come to the ever-growing Greater Freehold Area?

Over 1 ac., 12 yr. old, 9 room home near Freehold Hospital **\$99,900.**

Victorian Professional Home/Office Combination with 11 rooms and 2 baths **\$125,000.**

10 room 2 bath home, zoned Professionally, near Court House and Hall of Records; next to large public parking lot **\$81,500.**

Ideal Professional location. One-story Brick home, 4 rooms, bath & half. Across from Monmouth County Court House **\$82,500.**

PLEASE CALL. We will be glad to send you more detailed descriptions of any of the above properties.

(201) 462-6464



46 W. Main St., Freehold, N.J. 07728

CLASSIFIED ADVERTISEMENTS

PEDIATRIC ASSOCIATE—New Jersey shore area, 1 1/2 hours to New York City and Philadelphia. Write Box No. 224, c/o JOURNAL MSNJ.

GASTROENTEROLOGIST/INTERNSHIP—31, ABIM certified, university-trained in all procedures. Seeks partnership, group practice. Also general internal medicine. Available July 1981. Write Box No. 223, c/o JOURNAL, MSNJ.

GENERAL SURGEON—With twenty-five years experience, interested in changing to Industrial Medicine, preferably insurance examinations; compensation or liability evaluations. Also full-time position in industry will be considered. Write Box No. 225, c/o JOURNAL, MSNJ.

GENERAL SURGERY RESIDENT—Seeking General Surgery group or partnership practice, available July 1981, Board eligible. John L. Driscoll, M.D., 631 Avenue E, Bayonne, N.J. 07002.

OB/GYN—Board eligible. Seeking HMO associates. Hospital based, partnership or group practice opportunity. Available. Write Box No. 227, c/o JOURNAL, MSNJ.

PATHOLOGIST—Available. A/P certified, C/P eligible, Pathology. Hyderabad, India 1964. Seeks private lab, hospital, etc. Syed A. Hadi, M.D., 162 N. Heck Hill Road, St. Paris, Ohio 43072. (513) 663-5842.

PHYSICIAN—GP, desires part-time position (clinic, other). Available evenings and weekends. Please respond to: M.D., P.O. Box 334, Belle Mead, N.J. 08502. Telephone (201) 359-1246 evenings.

PULMONARY INTERNIST—ABIM, University trained all phases Pulmonary Medicine. Seeks practice opportunity, available July 1981. Write Box No. 209, c/o JOURNAL, MSNJ.

PRACTICE—Active, established Family Practice. Cherry Hill-Haddonfield area. Fully equipped—office sharing—Corporation available—High income. For information write Box No. 226, c/o JOURNAL, MSNJ.

PRACTICE FOR SALE—Union County, established Internal Medicine or Family Practice. Will introduce and advise. Building also available which has rental property. Close to hospitals and medical centers. Call after 6 p.m. (201) 654-5974 or 654-6706.

FOR SALE—Medical and Surgical Equipment and office furniture. Small settee with two chairs, upholstered; desk, etc. (201) 366-2557.

FOR RENT—West Hampton Beach Front Condo. July 1—September 8. Two bedroom, 2 baths, family room, sun deck. Boating & tennis; pool facilities. Call Rosemarie P.V. Hospital (201) 664-4000 ext. 274. Evenings (201) 447-0432.

OFFICE SPACE TO SHARE—with semi-retired G.P. Ideal location in Erdman Medical building. About half-mile from ext. 9, N.J. Turnpike on Route 18. East Brunswick population 35,000. Four hospitals all 10-25 minutes away. Full or part-time. Call (201) 545-4339.

SHARE MEDICAL OFFICE SPACE—Newly decorated and equipped office in Roselle Park and in Bayonne available on a time rental basis. Roselle Park (201) 241-0200, 505 Chestnut Street; Bayonne (201) 823-2977, 778 Kennedy Boulevard.

OFFICE SPACE—Edison. New Modern Professional Building. Will divide. Need all specialties. On site parking, near all major highways. Call Dr. M. Bronstein (201) 826-5606.

OFFICE SPACE—Linden. Medical suite, 750 square feet, available. Waiting room, consultation room, three examining rooms, nurses' station, lavatory. Established location 25 years. Community need. Suburban doctor's row. Four hospitals in area. (201) 486-8653 or write Box No. 221, c/o Journal, MSNJ.

OFFICE SPACE—For Rent, Medical office space, new and fully equipped. Part/full-time. Ocean Medical Park, Brick Town, N.J. (201) 295-9003.

FOR LEASE—Professional office for lease. Excellent location, Morris County, New Jersey. Phone (201) 366-2557.

OFFICE SPACE—1,300 square feet, can be divided. Growing suburban area, universities, office parks, three teaching hospitals. Ten other health professionals, including x-ray and lab in building. Madison Medical Center, 28 Walnut Street, Madison, N.J. 07940.

OFFICE SPACE—Newark-Mt. Prospect Ave.-Forest Hill. Physician's office on ground floor location of new building, 1000 feet, large waiting room, nurse's station, four large examining rooms, plus three other rooms. At present used as a clinic. For details call (201) 482-2313.

OFFICE SPACE—Woodbridge. Prestigious office suites available. 73 Main Street. (201) 548-3670.

INFORMATION FOR MEMBERS—RATES—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT**: Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o THE JOURNAL" as six words. **COPY DEADLINE**: Fifth of preceding month.

**Now Signing Leases For
SPRING 1981
OCCUPANCY
SPACES AVAILABLE
10,500 sq. feet New Construction**

**MEDICAL/
PROFESSIONAL
OFFICES**

**Prime Location:
MIDDLESEX COUNTY
For information call
201-828-2715**

DISABILITY INCOME-PROFESSIONAL OVERHEAD EXPENSE

Issued at ages 61-67
up to \$5000.00 per month—Professional Overhead Expense
up to \$1000.00 per month—Disability Income
Issued subject to usual medical & participation limits

Please call—reverse charges

Robert E. Segal, CLU
Field Representative
Monarch Life Ins. Co.,
P.O. Box 324
Mt. Freedom, N.J. 07970
Telephone (201) 992-5137

LOCUM TENENS—COMPHEALTH

Our medical group can place a well-qualified physician in your practice during your absence. For more information call or write: Comprehensive Health Systems, Inc.

175 West Second South
Salt Lake City, UT 84101
(801) 532-1200

PHYSICIANS (Part Time)

Ob/Gyn Physicians for prenatal care and deliveries of women enrolled in the Women's Care Center at Cooper Medical Center. Requirements: New Jersey license; must have passed part 1 of ACOG Boards.

Please Call Marta Silverberg at (609) 342-2268.

PHYSICIANS

All specialties. Regularly scheduled hours, respectable salary, malpractice paid, free health/dental, 30 days paid vacation, many family benefits and more. Must qualify for commissioned officer in Navy Medical Corps.

Send C. V. to
Medical Programs Officer
128 N. Broad St.
Philadelphia, PA 19102
or call
(215) 597-9680
or 564-3820.

DIRECTOR EMERGENCY MEDICINE

St. Francis Medical Center, a 483 bed Major Teaching hospital is seeking qualified candidate for Director, Dept. of Emergency Medical Services.

Minimum qualifications; Diplomate, Board of Emergency Medicine of; Board certification in a clinical speciality and the ability to obtain certification in Emergency Medicine within six years. Successful candidate, will also participate in the Medical Center's medical education programs and have limited clinical responsibilities.

Starting salary of \$70,000 to \$100,000 depending on professional credentials and level of experience in the practice of Emergency Medicine. Malpractice insurance and an excellent fringe benefit package provided.

St. Francis Medical Center is located in an established residential area of Trenton, NJ, within easy driving distance of Princeton, New York City and Philadelphia.

Mr. Robert Moonan
Chairman Search Committee
St. Francis Medical Center
601 Hamilton Ave.
Trenton, New Jersey 08629

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$16,100 to \$18,400 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

Journal of
the Medical
Society of

New Jersey



APPENDIX Confily Antipodagrici Specialis

^{Sanimus}
X CONSILIA SEE CIA -
LISSIMA

*Donnbrauch der Witsch und Sings
Länge Loh von der Eicht/
Tear der Kramdang/
Lob des Podagrumb's/
Lud des den Vanghlingung/
Arrend gabrauch des Signi
Sassafras.*

*Lunigk 1625. in Kurlingung
Zaherich Schürer des Jungens
Montchiab Geynd Vindfifur
Cui later est Bacchus, mater
Cytherea PODAGRA.
Ellecebra prosto sunt tremor, ma,
Desidis ^{dolor} sa guies, effrenis motus,
Quodlibet ^{abundans} sic sculpis picta stat
ante tuos.*



The Library
Acquisitions Division



"Punch Cures the Gout"
R.P. Wedeen, M.D.

Subclavian and Axillary
Aneurysms
M. Israel, M.D., et al.

Amenorrhea
M.A. Pelosi, M.D.

Due Process in Applying for
Hospital Privileges
J.E. George, M.D., J.D.

Complete Table of
Contents on page 160

LIBRARY
U.C. SAN FRANCISCO

MAR 25 1981

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

*Check this list
against your
coverages*

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$7,500 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide: In the male: Eunuchoidism and eunichism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

When impotence is due to androgenic deficiency.

Android® ⁵Buccal / ¹⁰Oral / ²⁵Oral
mg / mg / mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



Officers and Trustees

PRESIDENT	Augustus L. Baker, Jr., M.D. (Morris)	Dover
PRESIDENT-ELECT	Armando F. Goracci, M.D. (Gloucester)	Woodbury
FIRST VICE-PRESIDENT	Howard D. Slobodien, M.D. (Middlesex)	Perth Amboy
SECOND VICE-PRESIDENT	Alexander D. Kovacs, M.D. (Union)	Scotch Plains
IMMEDIATE PAST-PRESIDENT	Alfred A. Alessi, M.D. (Bergen)	Hackensack
SECRETARY	Arthur Bernstein, M.D. (Essex)	East Orange
TREASURER	Rudolph C. Gering, M.D. (Mercer)	Pennington

Trustees

CHAIRMAN	
William Greifinger, M.D. (1981) (Essex)	Belleville
Meyer L. Abrams, M.D. (1982) (Burlington)	Cherry Hill
Frank Campo, M.D. (1981) (Mercer)	Trenton
Douglas M. Costabile, M.D. (1981) (Union)	Murray Hill
John J. Crosby, Jr., M.D. (1981) (Hudson)	Jersey City
Anthony P. DeSpirito, M.D. (1982) (Monmouth)	Neptune City
Ralph J. Fioretti, M.D. (1983) (Bergen)	Rochelle Park
Palma E. Formica, M.D. (1981) (Middlesex)	Old Bridge
Sherman Garrison, M.D. (1983) (Cumberland)	Bridgeton
John P. Kengeter, M.D. (1981) (Ocean)	Toms River
Richard E. Lang, M.D. (1981) (Passaic)	Passaic
Myles C. Morrison, Jr., M.D. (1982) (Morris)	Morristown
John A. Surmonte, M.D. (1981) (Salem)	Penns Grove
Frank Y. Watson, M.D. (1983) (Essex)	Montclair

Councilors

FIRST DISTRICT	(Essex, Morris, Union, and Warren Counties)
Merton L. Griswold, Jr., M.D. (1981)	Plainfield
SECOND DISTRICT	(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1983)	Newton
THIRD DISTRICT	(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Albert F. Moriconi, M.D. (1982)	Trenton
FOURTH DISTRICT	(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1981)	Haddonfield
FIFTH DISTRICT	(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Ronald M. Fisher, M.D. (1983)	Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982)	Hackensack
William J. D'Elia, M.D. (1981)	Spring Lake
Frederick W. Durham (1982)	Haddonfield
Karl T. Franzoni, M.D. (1982)	Trenton
John S. Madara, M.D. (1982)	Salem
Henry J. Mineur, M.D. (1982)	Cranford

March 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Julio C. del Castillo, M.D.
John F. Marshall, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.
Harold Arlen, M.D.
Alfonse Cinotti, M.D.
Stuart D. Cook, M.D.
Robert Dodelson, M.D.
Wm. A. Dwyer, Jr., M.D.
Norman H. Ertel, M.D.
A. Olusegun Fayemi, M.D.
Arthur Goldfarb, M.D.
Robert A. Goldstone, M.D.
Murray Kahn, M.D.
Monroe S. Karetzky, M.D.
Avrum L. Katcher, M.D.
Sidney Ketyer, M.D.
Bernard J. Koven, M.D.
Joel D. Levinson, M.D.
Henry R. Liss, M.D.
Robert M. MacMillan, M.D.
Geobel A. Marin, M.D.
Murray Nussbaum, M.D.
Christopher M. Papa, M.D.
Victor Parsonnet, M.D.
Irwin Pollack, M.D.
Bernard A. Rineberg, M.D.
Edwin L. Rothfeld, M.D.
Benjamin F. Rush, Jr., M.D.
Morris H. Saffron, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Sheldon D. Solomon, M.D.
Lloyd N. Spindler, M.D.
A. Arthur Sugerman, M.D.
Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 922. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal MSNJ*, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

At 4:25 PM mild mannered Mindy Sternberg made a harried doctor smile.

Mindy is part of our special Blue Shield professional relations staff. Mindy and her colleagues specialize in answering physicians' questions. You can depend on our professional relations staff for quick answers to your questions regarding claims, billing information, and contract interpretation.



*"It's our job to
make things simple."*

In addition, professional relations staff members handle the enrollment of new participating physicians, and the training of medical assistants.

So, next time you run into a Blue Shield related problem, call on us for the answer.



Blue Shield of New Jersey

Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

166 PROFESSIONAL LIABILITY COMMENTARY

EDITORIALS

- 169 Inappropriate Prescription Drug Use
170 Recertification by Examination: "Trick or Treat"

172 JEMPAC REPORTORIAL

ORIGINAL ARTICLES

- 173 Subclavian and Axillary Aneurysms
M. Israel, M.D.; B. Sussman, M.D.; I.B. Ibrahim, M.D.; I. Dardik, M.D.; M. Kahn, M.D.; H. Dardik, M.D., Englewood
181 Mucosal Biopsy in Evaluation of Inflammatory Bowel Disease
Robert R. Rickert, M.D., Livingston

CASE REPORTS

- 187 Aortic Dissection: Rare Cause of Superior Vena Cava Syndrome
D.J. Riley, M.D.; R.T. Liu, M.D.; S. Saxonoff, M.D., Piscataway
191 Aneurysm of the Pancreaticoduodenal Artery
E.C. Mariano, M.D.; R.S. Greco, M.D., Piscataway

STATE OF THE ART

- 195 Amenorrhea: Modern Office Evaluation
Marco A. Pelosi, M.D., New Providence

MEDICAL HISTORY

- 201 "Punch Cures the Gout"
Richard P. Wedeen, M.D., East Orange

SPECIAL ARTICLE

- 207 Physician Due Process in Applying for Hospital Privileges
J.E. George, M.D., J.D.; M.S. Quattrone, Woodbury

211 THERAPEUTIC DRUG INFORMATION

213 COMMENTARY

215 YOUR CONGRESSMAN SPEAKS

A Whole New Ballgame
The Honorable Frank J. Guarini, Washington, D.C.

217 NUTRITION UPDATE

219 REPORT OF NOMINATING COMMITTEE

220 AMENDMENTS ON REQUIREMENTS FOR ISSUING PRESCRIPTIONS

221 BME RULE 13:35-6.6—THE PRESCRIPTION BLANK

DOCTORS' NOTEBOOK

- 222 Trustees' Minutes: December 21, 1981
225 Physicians Seeking Location in New Jersey
228 Cardiopulmonary Resuscitation Program for Industry
228 CMDNJ Notes
229 AMA Video Clinic
229 Report from the Foundation

230 LETTERS TO THE JOURNAL

235 CME CALENDAR

240 OBITUARIES

242 BOOK REVIEWS

Cover

The cover (supplied by the author of the article entitled, "Punch Cures the Gout," page 201, this issue) is the title page from a book on podagra by M. Pansa published in 1623. Panels at the top and on the sides illustrate a life of indulgence and debauchery; the consequences are illustrated in the bottom panels showing a gouty old man on crutches surrounded by Venus and Bacchus and the bedridden debauchee.



You're Invited to Tour Our Facilities

The majority of physicians have never toured a modern rehabilitation hospital, and because of this we're extending an open invitation.

New Jersey Rehabilitation Hospital, located by Exit 145 of the Garden State Parkway, is a specialty hospital which treats catastrophic injuries to spinal cord and brain, stroke, quadriplegic, paraplegia, loss of limb, musculo-skeletal injuries, neck and low back injuries, and other mental and physical impairments, often resulting from automobile or work accidents.

To arrange for an escorted tour of our facilities, call Bucky Harris, at (201) 673-1860. We believe you'll be impressed with modern rehabilitation medicine.



New Jersey Rehabilitation Hospital

Owned and operated by Moderncore Centers of America, Inc.

240 Central Avenue, East Orange, NJ 07018 • 201-673-1860

Bertrand J. Bensam, MD, Medical Director • Stanley Shepard, Administrator

Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities and the American Board for Certification in Orthotics and Prosthetics Inc.

Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white glossy

prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.


COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.



Acute pain is no laughing matter.

The first prescription for the first days of acute pain Empirin® \bar{c} Codeine #3


Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg. (Warning — may be habit-forming). 

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin \bar{c} Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin \bar{c} Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin \bar{c} Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming.) 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSEAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

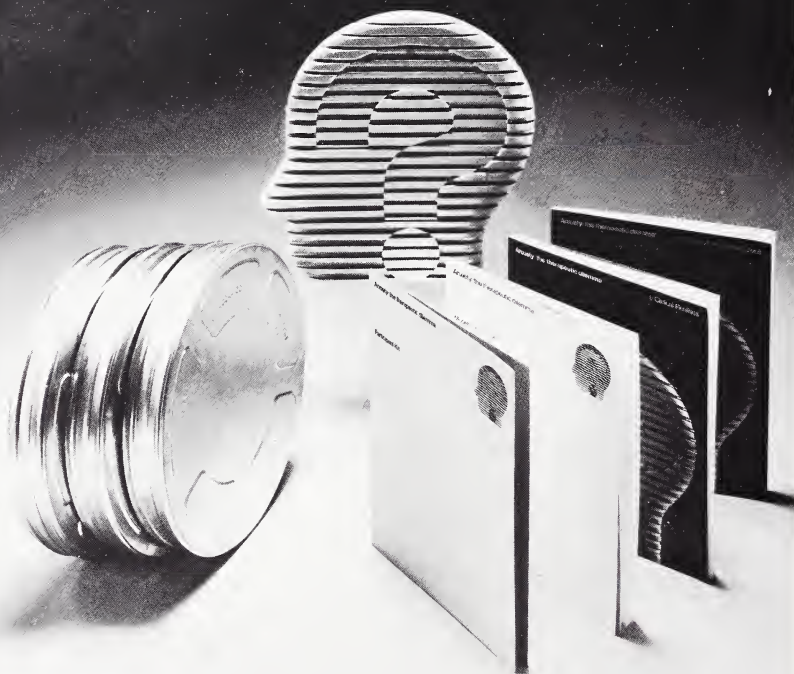


Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

**Now...today's issues
in anxiety management
are confronted in a unique program
for primary care physicians**

Anxiety: the therapeutic dilemma

Multimedia Continuing Education Program



Ideas about anxiety management are changing. Problems have surfaced. There is concern about dependence on minor tranquilizers and new findings on receptor sites in the brain. There is a trend toward short-term therapy and interest in nondrug alternatives. Because anxiety can disable, the need to treat continues in daily practice. Primary care physicians require up-to-date information. This program can provide it.

Current Views and Opinions from Eminent Authorities

Offered free of charge, this multimedia seminar is based on a major symposium. It integrates the views of nationally known clinicians with case material to demonstrate: 1) keys to differential diagnosis, 2) recognition and management of dependence-prone patients, 3) ways to minimize tranquilizer dependency, 4) guidelines for selecting drug and nondrug therapies, 5) how the biochemistry of anxiety can affect treatment modalities. And more.

CME Accreditation

The complete program, **Anxiety: the therapeutic dilemma**, is designed to provide up to a total of 26 credit hours in Category 1, PRA/AMA. The maximum number of hours may be obtained as follows:

Seminar(s)

When presented by an accredited CME provider (hour for hour) . . . up to 8 hours

Self-Study Programs

Designed to provide credit hours indicated when completed according to instructions:

- Two monographs (completed as a unit) . . . up to 6 hours
- Six self-study units (2 hours each) . . . up to 12 hours

Unique Interactive Format Stimulates Participation

More than a conventional lecture, this seminar provides opportunity (and guidance) for the kind of interaction that promotes understanding and anchors useful ideas. Guest lecturers are available and all elements needed for an effective program are included: films, moderator's guide, participants' workbooks, monographs, publicity material, etc.

Flexible Program Design

Anxiety: the therapeutic dilemma is a versatile program with an outstanding faculty, pertinent content and lively format. It can be conducted in a variety of ways to meet your scheduling needs: • Full day — 8 hour seminar • Half day — 4 hour seminar • 1 or 2 hour course

For further information, mail the coupon below, or call toll-free 800-526-4299. In New Jersey, call (201)-636-6600.

Anxiety: the therapeutic dilemma

was produced under a grant from Abbott Laboratories



1-0791 1033394

M.E.D. Communications
655 Florida Grove Road
Hopelawn, NJ 08861

Please send me full details on faculty, agenda, accreditation and booking for the CME seminar, **Anxiety: the therapeutic dilemma**.

Name _____
(please print)
Title _____
Institution _____
Street _____
City _____ State _____ Zip _____

Featuring: Rule 4:21 Panel Determination Not Constitutionally Defective What's New in Malpractice Insurance Policies

RULE 4:21 PANEL DETERMINATION NOT CONSTITUTIONALLY DEFECTIVE

The plaintiff in the case of *Suchit v. Baxt et al.* alleged that the defendants negligently failed to adhere to the requisite standard of medical care required in the treatment of her deceased husband.

The Rule 4:21 medical panel, at its hearing, unanimously decided in favor of the defendant. Plaintiff appealed the panel decision to the Appellate Division arguing that the admission of the panel determination at trial was constitutionally defective.

Plaintiff claimed that the admission of panel findings at trial denied her the right to cross-examine panel members to ascertain their biases. The Court found this argument to be without merit, commenting that all panel members are deemed unbiased and that the plaintiff did not object to the panel members prior to their decision.

The Court found: "The fact that Rule 4:21 may provide for the admissibility of a panel finding does not violate the right to cross-examination even though the findings technically can be called hearsay. With proper safeguards, the lack of cross-examination hearsay argument does not create a constitutional impediment. The twin tests of reliability and confrontation are not always constitutionally mandated.

"In addition, Rule 4:21-5d provides for the medical panel member to be called as a witness and be cross-examined, which safeguards the constitutional right.

"While one cannot cross-examine a document, in this matter the parties control what is presented to the panel and are given an opportunity to explain, refute and rebut the evidential material of their adversary. Greater due process protection is afforded in this rule than in other rules and case law dealing with non-testimonial evidence."^a

Plaintiff further argued that the admissibility of the panel's finding impaired her right to a jury trial. To this the Court replied:

"She asserts that a lay jury, hearing the unanimous decision of a panel (three court-appointed experts) will conclude that it lacks the knowledge and expertise to overrule the panel.

"The jury is still the ultimate trier of the fact. Once the panel has considered the evidence and a decision has been rendered, plaintiff is free to proceed to trial and present her case to a jury. There is no question that an adverse decision by the panel casts an increased burden on the claimant. Such a burden, however, is not so oppressive as to impair the party's right to a jury trial."^a

The Court further stated:

"One of the basic purposes of Rule 4:21 is to identify meritorious claims and to alert counsel and claimant to the weaknesses of their position where their claims are lacking in merit. Rather than acting as a burden to the bringing of suit, panel determination benefits the parties by allowing them the

unique opportunity to obtain an objective opinion.

"Historically jurors, for the most part, have proved their independence. They guard their roles with unique jealousy and refuse to allow themselves to be unduly influenced. For the jury the panel discussion is, in essence, in the nature of expert opinion which they may hear and accept or reject as they would any other expert evidence. The mere fact that the jury is exposed to a preliminary investigation or determination is not sufficient influence to rob it of its function as arbiter of the facts."^a

This decision by the Appellate Division assists in strengthening Rule 4:21 panel hearings as a mechanism toward identifying meritorious claims and eliminating nuisance claims.

WHAT'S NEW IN MALPRACTICE INSURANCE POLICIES

(This item was prepared by Mr. William Reilly, Vice President of Underwriting, NJ Medical Underwriters)

"Claims made" is a term frequently heard these days when current trends in physicians' professional liability insurance are discussed. This modified form of a standard policy contract, conceived by the innovative underwriters at Lloyd's of London in the late 1960's, gradually spread to a number of United States insurers during the 1970's. In the 1975 malpractice crisis when the voluntary domestic insurance market collapsed, many doctor-owned companies were formed to fill the void. A large percentage of these companies found the claims-made policy particularly well suited to their needs. The accounting methods required with this type of insurance did not necessitate the substantial amounts of premium surplus normally set aside for future payments with the traditional occurrence policy. Thus, many minimally financed companies, which otherwise would not have been able to pass the requirements of their state insurance departments, were able to begin writing insurance. Their ultimate strength, without additional infusions of surplus should further hard times occur, is a matter of continued speculation.

This interesting form of insurance contract contains several unique features. The first difference is found in the time period for the reporting of claims. The standard occurrence policy is required to respond to claims or lawsuits which are alleged to have occurred during the policy period regardless of when they are reported. For example, a teenager may

^aThis item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

^aThe Appellate Court's comments are as they appeared in the *New Jersey Law Journal*, December 25, 1980.

assert a claim against his pediatrician today, charging the doctor with negligence during the neonatal period. The pediatrician, if he were insured by an occurrence type policy, would be protected by the policy and the company insuring him at the time he treated the baby. The extended time between the event at issue and the reporting of the claim is what frequently is called the long tail of malpractice claim development. This unknown amount of future liability exposure is what makes the setting of accurate premium rates for malpractice insurance an exceedingly speculative procedure.

The claims-made policy form attempts to moderate the uncertainty of the long-tail effect by limiting coverage for claims arising under a policy term to those which are made within a prescribed reporting time—usually the policy period plus 36 months following discontinuance. It is important to note that this limitation could leave something to be desired in terms of protection for the insured. In our example of the pediatrician, if he happened to retire or switch insurers between the time of his patient's birth and his reaching legal age, he would not be covered for the claim made.

The potential for uncovered liabilities results in another interesting aspect of the claims-made policy—tail coverage. Protection against late arising claims may be provided for by the purchase of an extended reporting endorsement, commonly called tail coverage. Naturally, an additional premium is required in contrast to the one-time price set for an occurrence policy. Most companies will guarantee to offer this type of extended reporting endorsement. The unknown quantity is the amount of premium they will charge at the time a doctor stops his policy and wants to buy future claim reporting protection. This proviso gives the insurance company a flexibility in the future that they don't have normally. If their rates have been inadequate, here's a final chance to catch up. This proviso also gives the doctor policyholder an unknown future premium cost which could arise at an inopportune time. It may come after retirement or a disability when finances are tight. If he doesn't like the price quoted by his original insurer, his bargaining position will be severely restricted if no other insurer is willing to sell him coverage.

The attractive offset to the future premium assessment is the low initial cost of the claims-made policy. Since the first policy only covers that year plus 36 months, the rate is only a percentage of the corresponding occurrence premium. Succeeding years' policies have a gradually increasing rate until, at the fifth year, the premium is within 4 percent of the occurrence price.

Different companies use slightly different rate development formulas. The important thing to remember in all these pricing schedules is that the insurance company expects an insured ultimately to pay a total amount for his policy at least equal to the equivalent occurrence premium. Since the final total premium cost is an unknown until some point in the distant future, physicians would be well advised to look carefully at all the facets of new claims-made policies which seem to be very attractively priced. The New Jersey Department of Insurance refused to allow this type of policy to be sold to doctors in 1976. Since that time there has been increasing pressure exerted to approve the marketing of this form of insurance. One wonders how long they will be able to resist.

MIENJ—NEW PRACTITIONER DISCOUNT EXPLAINED

William Reilly, MIENJ's Vice President of Underwriting, reports that there have been some misconceptions regarding the eligibility requirements of the 50 percent discount to new practitioners.

The intention of the new practitioner rate, which is based on part-time practice and continues for a maximum of 18 months, is to recognize the reduced patient load associated with the establishment of a new practice.

New practitioners who desire to apply for the discount must meet the following criteria:

1. It must be his or her first practice, with no history of previous full-time employment.
2. It must be a new practice with no established volume.
3. The practice must originate within 18 months of the completion of his or her training.

Regrettably, not every first-time practitioner qualifies for the reduced rate. Situations which are unusual are individually evaluated by the underwriting staff. For information call (609) 896-2404.

DID YOU KNOW

... The New Jersey Medical Malpractice Reinsurance Authority has requested the New Jersey Department of Insurance to grant a 28 percent rate increase.

... "The Illinois Supreme Court recently upheld the constitutionality of legislation requiring medical malpractice actions to be filed within four years of an injury, regardless of when the injury is discovered. The discovery rule's long tail has made it hard for insurers to estimate their liability. Shortening the tail may encourage carriers to stay in the market if another malpractice crisis, predicted by many experts, erupts." *Medical Economics*, Nov. 10, 1980.

... "Before-and-after photos are most helpful when treating a serious injury," says Philadelphia defense lawyer James Griffith. "If the treatment result lands you in court, showing what you had to work with may make the jury more sympathetic." *Medical Economics*, Nov. 24, 1980.

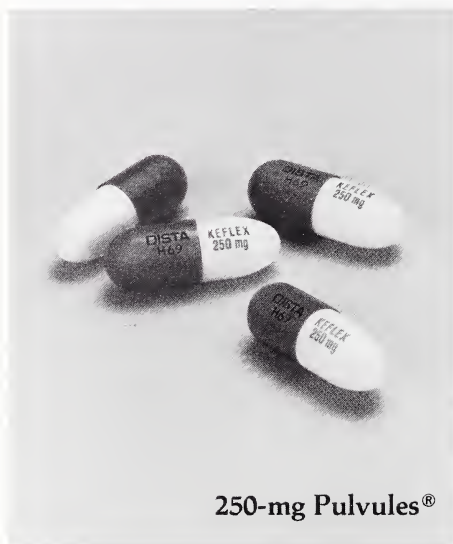
... "Spoken consent or consent implied by the patient's conduct, if *proved*, will satisfy legal requirements as well as consent in writing. However, many cases have shown that an oral or implied consent may be difficult to prove in court. *Thus, the main purpose served by a written consent is that it provides the most direct, effective proof of a valid consent.*" Rosoff AJ: *Informed Consent*, 1981, p. 281.

PHYSICIAN ALERT: Theft of x-rays for silver content

The Medical Inter-Insurance Exchange of New Jersey has informed this department of the burglarizing of three physicians' offices of all their patients' x-rays. Two of these offices were located in the Lakewood area and one was located in Morristown. Physicians are reminded to evaluate the security system for patients' x-rays housed in their offices.

Any physicians experiencing a theft of x-rays should send a copy of the police report to their malpractice insurance carrier. The police report would be kept on file in the event of future medical malpractice actions in which the stolen x-rays might be used as evidence.

easy to take



Keflex® cephalexin



Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Additional information available
to the profession on request.

Inappropriate Prescription Drug Use

Most physicians probably realize that virtually all or a large number of prescription drugs are used inappropriately. We are familiar with the patient who takes only one or two doses of the t.i.d. medication or who misses enough doses so that a significant number of capsules remain when the original prescription should have been exhausted. Some patients accept a prescription for a medication and never fill it!

Such behavior may prove bewildering when we anticipate improvement or recovery from a short illness and it fails to occur. Why does this happen? Directions may prove confusing to the patient, e.g., before meals, after meals or with meals. Whether the prescription order is q.i.d., q.4.h., q.6.h. or whatever, many patients take three or fewer doses daily. Some patients simply oppose the ingestion of all drugs; others do not hesitate to share their medications with family members or neighbors. This kind of inappropriate prescription drug use is not in the patient's best interest, but we tend to shrug it off and continue to try to educate and encourage our patients to take the drugs we prescribe as instructed.

Drug misuse and drug abuse, however, represent a different "kettle of fish." Since drugs are any chemical substances which cause a physical or mental change, or both, it should be clear that drug misuse has occurred in every human society, even while that society has been the beneficiary of pain relief, controlled tranquility in times of great stress or bedtime hypnosis when temporary internal or external factors interfere with sleep.

The vast intake of caffeine, a stimulant, on a world-wide basis in the form of coffee, tea and cola soft drinks may be an example of universal drug misuse. Aspirin, over-the-counter cold remedies, allergy preparations, appetite suppressants, laxatives (a very common one), vitamins and food supplements probably all are susceptible to misuse. Virtually every drug can be harmful, dangerous or even fatal when misused. Phenacetin nephropathy is such an example. Alcohol, a depressant, of course, is in a special class of its own.

Drug abuse, mainly related to psychoactive drugs, has been the lot of human society since prehistoric times, but civilization and sophistication have made the problem worse. Alcohol probably is the oldest drug; there is evidence that wine and beer use goes back to 6400 B.C. in Anatolia and 4500 B.C. in Egypt.

Physicians, however, have been involved in the explosive abuse of drugs in this country and elsewhere in the world, especially since World War II, the Korean War and the Vietnam conflict. Our involvement mainly has been one of treating drug overdose in hospitals, dealing with distraught parents of addicted children or the counseling and referral of patients to treatment centers.

Unfortunately, the average practitioner may consider the problem of drug abuse in terms of "street drugs," which find their way through illicit pathways originating in foreign countries, in conjunction with organized crime. It never may have occurred to many of us that we may be playing an active role in this problem, whether that be innocent or otherwise.

Statistics originating from federal sources suggest that seven million Americans use prescription drugs for non-medical purposes, i.e., they misuse or abuse drugs commonly prescribed by physicians. These are barbiturates, tranquilizers, amphetamines, narcotics and nonnarcotic analgesics and other prescription drugs. Eight of the ten most common drugs which are responsible for drug abuse deaths are prescription drugs.

When drugs with potential for abuse are prescribed too readily, in too large a quantity with too many refills authorized, especially to vulnerable patients, we physicians are indeed contributing to this devastating condition which destroys careers, individuals and families. The most susceptible individuals to drug abuse are the young and the elderly and the patients with free-floating anxiety or psychophysiologic reactions, indicated by pain, insomnia or a myriad of somatic manifestations. It takes much less time to dash off a prescription for a barbiturate than to seek out the elusive basis for anxiety and to counsel its victims.

Physicians must realize how frequently prescription drug diversion occurs, primarily at the "retail" level, through physicians, pharmacists, and other health professionals, such as hospital-based nurses.

Drug and alcohol abuse have been recognized as major public health problems by governmental agencies, organized medicine, industry and virtually every other responsible facet of society for many years. The Medical Society of New Jersey, through its Committee on Drug and Alcohol Abuse, has taken a serious look at this issue and has become concerned at the medical profession's failure to pay enough attention to prescription drug abuse. On recommendation of the Committee, the Board of Trustees officially recognized the seriousness of the point and "endorsed a specific education program for all physicians to address their role in this significant health problem." [prescription drug abuse]

In preparation for an upcoming seminar on the subject, the Chairman of the Committee on Drug and Alcohol Abuse, Richard J. Corbett, M.D., attended a White House Conference which focused on "Problems of Prescription Drug Misuse, Abuse and Diversion." A consensus of the conference attendees was that each state should develop its own program to help prevent drug diversion. New Jersey has no plan thus far, but it is obvious that high-level planning and cooperation between the Governor's office, the State

Legislature, the State Department of Health, the Medical Society of New Jersey and other involved and interested groups will be essential.

On Wednesday, April 15, 1981, a symposium entitled "The Physician's Role in Drug Abuse" will be held at CMDNJ—Rutgers Medical School under the joint sponsorship of MSNJ's Committee on Drug and Alcohol Abuse and the Academy of Medicine of New Jersey. Speakers of national renown will discuss such topics as "Pitfalls in Prescribing

Controlled Substances" and "Hazards and Challenges of the Role of the Physician in Alcoholism and Drug Abuse."

Every physician in New Jersey should make a special effort to give thought to the problem of prescription drug abuse and to reexamine his own techniques and habits in regard to the prescription of controlled substances. Please attend the seminar and learn more about a terrible disorder in which the physician can play a major preventive role.

A.K.

Recertification by Examination: "Trick or Treat"

"On the basis of my ten years of experience, I have found disaffection and distrust for this system of examining physicians. Many who have participated, as I have, share these attitudes, but our rag-tag opposition is confronted by a monolithic establishment sustained by years of acquiescence; the millions in funds, budgets, and buildings of the Establishment; an entrenched, well-heeled bureaucracy of testers, statisticians and administrators; and an apparent lack of practicable alternatives," stated Dr. William H. Crosby, a former member of the National Board of Medical Examiners, Medical Test Committee, as well as the Hematology Test Committee of the American Board of Internal Medicine, in a recent article in *Forum on Medicine*.¹

When a physician of Dr. Crosby's stature and experience challenges certification of a physician in his specialty by multiple choice questions (MCQ) or by the use of patient management problems (PMP), he is indirectly challenging the use of this same mechanism for recertification in the specialty, since the principle is the same! We are testing "knowledge" and not "performance" which is the true "sine qua non." Though we twist and turn, and we deny and affirm, we still must come down to the fact that the patient is only interested in our performance on his case, and not in our esoteric knowledge in our specialty or subspecialty.

The business of continuing medical education has become a two billion dollar a year entity as the practicing physician attempts to meet the ego challenges, as well as the legal requirements for continuing medical practice engendered by the CME requirements for state licensure, state society membership, or recertification demands of the various boards. One must add to the course costs, the loss of income while studying for the exams, as well as the income lost while taking the CME courses. The cost adds up to billions of dollars more each year, which ultimately finds its way into the cost of medical care to the patient. This is a self-defeating situation, since we are at the same time trying to do everything we can to reduce medical care costs by every other technique we can think of. We have a finger in the hole in the dike while the flow over the top is drowning us.

In evaluating the certification and recertification examinations, a question which is answered correctly by 95 percent of the examinees is thrown out. Crosby points out the fallacy of this method by stating, "that easy question identifies the 5 percent who can't pour sweat out of a boot." Truly, it is more important to weed out the inept rather than identify the very bright. But the Boards still don't recognize this truism.

The "Patient Management Problem" was designed to

change the focus. However, this type of examination is harder to design and the information supplied is often inadequate and at best, misleading, since the choices are rigid, rather than elastic, as in the true clinical situation. As Crosby so aptly puts it: "The selections require value judgments in a theater of the absurd."¹

When PMPs and MCQs are compared, the ones who do best on MCQs are, as a rule, not those who do best on PMPs.¹ This would make it seem that *skill in taking* tests makes a big difference in the results, so that "knowledge" is not always the basis for doing well.²

"Objective testing can measure knowledge to some extent. It cannot measure skill. It cannot measure the compassion, morality, wisdom, generosity, and humanity that are part of the fabric of a good physician."¹

The use of mini-residencies² and evaluation of office practice³ have been suggested as alternatives to examinations by multiple choice questions, or patient management problems. Since the former methods are more attuned to our traditional style of learning and the problems of everyday practice, they may be more effective in solving the problem of CME, if there really is a problem rather than only a hypothesis.

We have built ourselves a Frankenstein monster that threatens to destroy us if we permit ourselves to continue to drift from one technique to another, from one method to another, as we now are doing. We must call an immediate halt to our present charade and begin to think as we do when treating a patient. Let us take a careful history, do a complete physical and laboratory examination, and arrive at a differential diagnosis—pinpoint the real problem and then, and only then, should we prescribe therapy. We must find and treat the cause of the problem—if we truly have a problem with *performance*—and then we can treat it actively and not with expensive futile placebos.

Truly it is better, as a physician "rather to be humane than encyclopedic." One can "always look up information, but where can (one) find humanity."¹

Arthur Bernstein, M.D.
Secretary, MSNJ

References

- ¹Crosby H: They don't use multiple-choice tests to license airline pilots. *Forum on Medicine*. July 1980, p 467.
- ²Bernstein, Arthur: Coping with Medical Obsolescence. *J Med Soc NJ* 75:678, 1978.
- ³Manning R, Lee V, Denson Teri A, Gilman A: Determining education needs in the physician's office. *JAMA* 244:1112, (Sept 5) 1980.

**NEW YORK
FERTILITY RESEARCH
FOUNDATION, INC.**

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

**ACCOUNTS
RECEIVABLE
PROBLEMS?**

N.J. Law Firm To Handle
Collection Matters
For Anesthesiologists
and Others Having
Large Volume Practices

*Services include advice on untangling
insurance claims.*

References available
Reasonable fees contingent upon
amount collected

For Information Call:
(201) 677-9019

**a group major medical
plan for doctors**

Officially Endorsed by The Medical Society of New Jersey

**BROAD COVERAGE
COMPETITIVE RATES
OPEN ENROLLMENT
JUNE AND DECEMBER**

For More Information Contact
Donald F. Smith and Associates

1 Airport Place, Route 206 North. P.O. Box 2197 • Princeton, New Jersey 08540 • (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross-Blue Shield

MEDICAL ISSUES FACING 97th CONGRESS

The 97th Congress faces a full agenda of issues, many of which are of prime importance to those in medicine and its related fields. The agenda includes proposals which are supported by physicians as well as those proposals which may be opposed actively. The list of medical issues includes:

- Health insurance, including proposals for government financing and for private sector incentives.
- Amendments to the Medicaid and Medicare programs.
- Reauthorization of health maintenance organizations.
- Hospital cost controls.
- Compensation for occupational diseases.

Senate Committees
Appropriations
Budget
Finance
Small Business
Labor
Energy
Environment
Banking
Commerce
Judiciary
Armed Services
Agriculture
Foreign Relations

Chairman
Mark Hatfield (Ore.)
Pete Domenici (N.M.)
Robert Dole (Kan.)
Lowell Weicker (Conn.)
Orrin Hatch (Utah)
James McClure (Idaho)
Robert Stafford (Vt.)
Jake Garn (Utah)
Robert Packwood (Ore.)
Strom Thurmond (S.C.)
John Tower (Tex.)
Jesse Helms (N.C.)
Charles Percy (Ill.)

MEMBERSHIP

JEMPAC is pleased to report the continuing increase of membership in all but two of the county societies. It is especially encouraging to note that Burlington, Gloucester, Union, and Warren have achieved ten percent or better of their total MSNJ membership in JEMPAC. A special notice of recognition is appropriate for Sussex County for achieving 20 percent of their MSNJ membership in JEMPAC.

JEMPAC's goal of 900 members for 1981 can be achieved if every county society would increase its present membership in JEMPAC by 16 new members.

In this gubernatorial election year, county medical society support could be rewarding for MSNJ physicians.

BAKER'S DOZEN (Nation's Business, Dec., 1980)

For the first time in a quarter of a century, the Senate of the United States is controlled by the Republican Party. Senator Howard Baker (R-Tenn.) is expected to become the majority leader in this new Senate and run the show. Although the membership of the standing committees will be about even, the big prizes are the powerful chairmanships. Into the catbird seats, so to speak, will move a baker's dozen of senators. Not until the 97th Congress convenes and officially forms will the new starting lineup be firm, but from all indications this will be the roster:

Report of Three Year JEMPAC Membership

County	1978	1978	%	1979	1979	%	1980	1980	%
	MSNJ	JEMPAC		MSNJ	JEMPAC		MSNJ	JEMPAC	
Atlantic	209	2	.9	218	3	1.	215	3	1.
* Bergen	1,085	55	5.	1,064	55	5.	1,053	73	7.
** Burlington	253	12	4.	241	20	8.	256	26	10.
* Camden	541	28	5.	529	28	5.	526	47	9.
Cape May	47	0	0.	51	0	0.	46	0	0.
* Cumberland	133	5	3.	127	5	4.	130	6	5.
* Essex	1,606	46	2.	1,564	48	3.	1,534	85	6.
** Gloucester	107	11	10.	105	8	7.	102	14	14.
* Hudson	512	5	.9	495	9	1.	514	18	4.
* Hunterdon	79	1	1.	79	1	1.	63	3	5.
* Mercer	578	19	3.	555	26	4.	564	32	6.
* Middlesex	546	14	2.	534	12	2.	539	20	4.
* Monmouth	561	12	2.	524	22	4.	557	30	5.
* Morris	506	21	4.	484	20	4.	482	28	6.
* Ocean	233	7	3.	255	8	3.	267	18	7.
* Passaic	690	13	1.	662	24	3.	657	36	5.
* Salem	44	4	9.	40	5	13.	43	3	7.
* Somerset	164	4	2.	159	1	.6	167	8	5.
*** Sussex	71	6	8.	74	2	2.	74	15	20.
** Union	743	61	8.	759	53	7.	772	109	14.
** Warren	65	5	7.	61	3	5.	59	8	14.
TOTAL	8,773	331	3.	8,580	355	4.	8,620	571	6.

*Increase in Membership

**10% or More of Total Membership

***Highest Increase in Membership

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

Subclavian and Axillary Aneurysms: Etiology, Manifestations and Management

MICHAEL ISRAEL, M.D., BARRY SUSSMAN, M.D.,
IBRAHIM M. IBRAHIM, M.D., IRVING DARDIK, M.D.,
MARK KAHN, M.D., HERBERT DARDIK, M.D., Englewood

Aneurysms of the subclavian and axillary arteries are rare lesions. Most occur as a result of trauma and only rarely is atherosclerosis the etiologic mechanism. Seven axillary and subclavian aneurysms in six patients are presented. Vascular reconstructive procedures were performed to prevent either pressure on the brachial plexus or distal embolization.

Aneurysms of the subclavian and axillary arteries occur infrequently. The authors treated six patients with four aneurysms involving the axillary artery and three aneurysms of the subclavian artery, during the past eight years. A review of our experience will demonstrate various etiologies and principles of therapy for this problem.

The rarity of atherosclerotic subclavian and axillary artery aneurysms requires a thorough investigation to identify more common etiologic mechanisms, such as trauma and the thoracic outlet syndrome. Appropriate therapy is based upon the cause as well as complicating factors such as distal vascular occlusion and ischemia of the hand.

CASE REPORTS

The clinical data and summary of the surgical procedures employed in this series are presented in tables 1 and 2.

Case 1—For eight months, a 55-year-old male construction worker experienced nonradiating left shoulder pain which was made worse by movement. He had sustained an injury to the left side of his chest several years previously, but there were no fractures. During the past few months, the pain became "throbbing" in character. Several examiners attributed the pain to "arthritis."

On physical examination, there was a five centimeter pulsatile mass in the left infraclavicular fossa. A bruit was audible over this mass. All carpal pulses were of good quality and blood pressure was equal in both arms. There were no

neurologic deficits. Arteriography demonstrated a large axillary aneurysm with displacement of the vessel (figure 1).

At operation, proximal control of the subclavian artery was obtained via a supraclavicular incision. The terminal portion of the axillary artery was controlled via an infraclavicular incision. The incision then was extended over

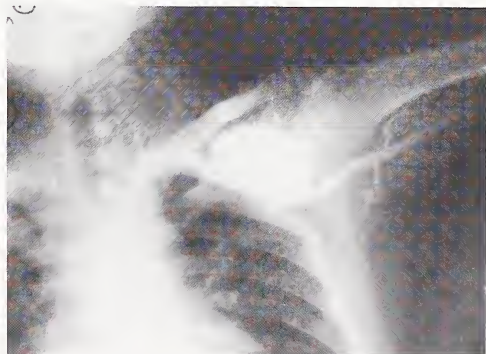


Figure 1—This arteriogram demonstrates a large left axillary aneurysm which displaces the artery in a downward direction.

*From the Vascular Surgical Service, Englewood Hospital, Englewood, New Jersey. Correspondence may be directed to Dr. Herbert Dardik, 375 Engle Street, Englewood 07631.

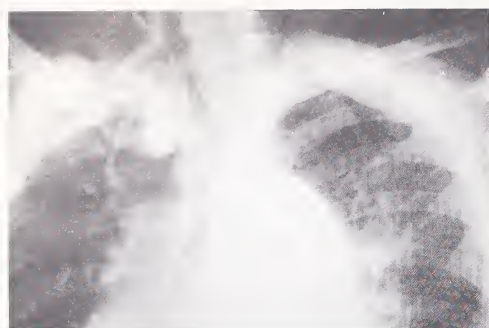


Figure 2—Arteriogram demonstrating bilateral axillary aneurysms.

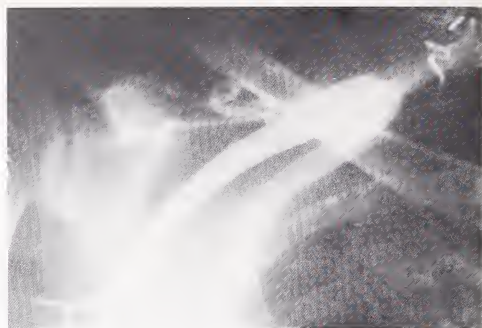


Figure 3—Aneurysm of right subclavian artery at the clavicular level.

Table 1
Etiology

Trauma.....	5
Cervical Rib	3
Fractured Humerus	1
Crutch	1*
Arteriosclerosis Obliterans.....	1

*Bilateral

Table 2
Surgery

	Resection Reconstruction		Exposure/Control		Adjunctive	
Axillary	④ Autologous Saphenous Vein	2	Infralavicular	3	—	
	Patch	1	Supra + Infralavicular	1		
	Dacron	1				
Subclavian	③ Primary Anastomatic	1	Supraclavicular	2	Cervical Rib Resection	3
			Supra + Infralavicular	1	Sympathectomy	2
	Autologous Saphenous Vein	2	Clavicular Resection	1	Brachial Thrombectomy	2

the mass and the aneurysm was resected. An interposition dacron graft was employed between the proximal subclavian artery and the distal portion of the axillary artery. The postoperative course was uneventful. The diagnosis of a true atheromatous aneurysm was established histologically by noting the presence of all three components of the normal arterial wall.

Case 2—A 68-year-old female presented with bilateral axillary masses. The patient required crutches for walking because of lower extremity paresis over many years. Arteriography confirmed the presence of bilateral axillary aneurysms (figure 2). Staged resections of these aneurysms were performed. Interposition vein grafts were employed to bridge the defects on either side. Her postoperative course was completely uneventful.

Case 3—A 77-year-old female fell onto her left shoulder while walking her dog. She sustained a fracture of the left humerus which was treated surgically. She later developed a mass in the left shoulder region, which was associated with distal sensory loss, weakness and pain in the left arm. An incision in the area of the mass resulted in major hemorrhage. Vascular consultation was obtained in the operating room and control secured of the infraclavicular segment of the axillary artery. A 5 x 6 centimeter false aneurysm of the axillary artery was present adjacent to a tear in the axillary

artery. Repair was obtained by primary anastomosis with vein patch angioplasty. The patient's postoperative course was excellent with restoration of flow to the left upper extremity and complete resolution of her neurologic deficit.

Case 4—A 53-year-old male with a history of claudication of his right forearm of seven months duration was hospitalized. Six months prior to this admission, the patient had been evaluated for a thoracic outlet syndrome because of complaints of paresthesias and weakness of the right hand. At that time, he underwent a right cervical rib resection and brachial artery thrombectomy. He did not obtain relief of the symptoms. Pertinent physical findings on this admission revealed a healed axillary scar and a right supraclavicular pulsatile mass. The right radial pulse was weak and the brachial and ulnar pulses were absent. Arteriography revealed an aneurysm of the subclavian artery at the level of the clavicle with embolic occlusion of the right brachial artery at the bifurcation (figures 3, 4). There was reconstitution of the arteries in the forearm.

Vascular control was secured at operation via supraclavicular and infraclavicular incisions. The middle third of the clavicle was resected to obtain better exposure. The aneurysm was resected and the defect bridged with a saphenous vein graft. Cervical sympathectomy also was performed. Postoperatively, the degree of claudication was



Figure 4—Occlusion of right brachial artery from subclavian artery embolism. The radial and ulnar arteries reconstitute in the forearm.

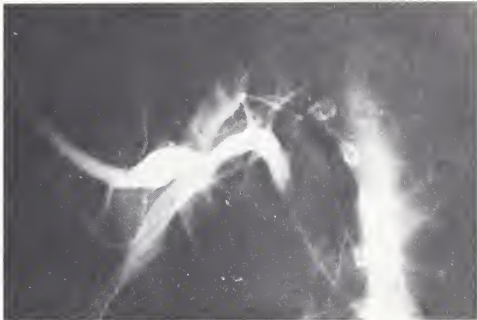


Figure 5—Poststenotic dilatation and aneurysmal formation of the retroclavicular subclavian artery. Cervical rib is not visualized on this film.



Figure 6—Poststenotic dilatation and aneurysmal formation of the right subclavian artery in a patient with bilateral cervical ribs.

much less. The right radial pulse was stronger and there was increased warmth of the hand.

Case 5—A 28-year-old female was hospitalized with recurrent episodes of pain in the right arm accompanied by intermittent episodes of cyanosis of the fingers. The right arm was especially painful on exertion. She had been treated for rheumatoid arthritis to no avail. On physical examination, there was a hard mass in the right supraclavicular area with a prominent subclavian pulsation. The right hand was cooler than the left; there was decreased venous filling but no pallor. Axillary and brachial pulses were present, but the pulse just above the antecubital fossa was absent.

X-rays of the cervical spine and chest revealed a right cervical rib. Angiography showed poststenotic dilatation of the subclavian artery distal to the cervical rib (figure 5) with embolic occlusion of the brachial artery above the elbow. There was reconstitution of the ulnar artery.

The cervical rib was resected via a supraclavicular incision and the subclavian artery aneurysm was resected. A saphenous vein interposition graft was employed to restore vascular continuity. Thromboembolism of the right brachial, radial and ulnar arteries and cervicothoracic sympathectomy were formed. Postoperatively, there was complete relief of the patient's symptomatology with restoration of the ulnar pulse.

Case 6—On routine physical examination a 25-year-old male was found to have a pulsatile mass underlying the medial aspect of the right clavicle. Arteriograms revealed bilateral cervical ribs with poststenotic dilatation of the right

subclavian artery (figure 6). There was no ischemia or neurologic deficit of the upper extremities.

At surgery, a supraclavicular incision was employed and the medial third of the clavicle was resected to permit adequate exposure of the aneurysm. The aneurysm, which measured 2.5 centimeters in diameter was resected. End-to-end anastomosis was accomplished. The distal half of the right cervical rib was resected. The postoperative course was uneventful.

DISCUSSION

Etiology—The rarity of atherosclerosis as the primary etiologic mechanism for subclavian and axillary aneurysms has been emphasized by Hobson *et al.*^{1,2} The majority of such aneurysms result from trauma due to clavicular fractures, cervical ribs or other manifestations of the thoracic outlet syndrome.³ In Hobson's series, four subclavian aneurysms were reported in the absence of thoracic outlet or a history of trauma. Atherosclerosis was considered as the primary mechanism.

Vascular injury associated with clavicular fracture is due to depression of the lateral fragment, reduction of the critical space behind the clavicle and compression of the neurovascular bundle. Nonunion of comminuted fractures is especially likely to cause this problem. If the injury is undetected, the increased motion of the nonunited fragments will result in vascular complications months or years after injury. Other aspects of the thoracic outlet syndrome include compression by a narrowed anatomic outlet, complete

cervical rib, anomalous first rib or deformed clavicle. Direct vascular injury by penetrating or blunt trauma also can result in aneurysms of the subclavian or axillary artery.⁴ Mycotic aneurysms have been documented but are extremely rare.^{5,6}

A unique etiologic form of extrinsic trauma is the chronic use of crutches.⁷ Abbott and Darling reported seven cases of axillary artery aneurysms secondary to crutch trauma and emphasized the dangers of embolization.⁸ Early resection with an interposition graft was recommended.

Clinical Manifestations—Although upper extremity aneurysms may be asymptomatic, the most common presentations are those of peripheral embolism and brachial nerve plexus compression. In a group of 21 patients, Heyden and Vollmar reported that almost half presented with arterial emboli as the first clinical manifestation of a subclavian artery lesion.⁹ Despite this finding, axillary and subclavian aneurysms are in fact unusual sources of brachial emboli; most emboli to the upper extremity are of cardiac origin. Baird and Lajos reported a single case of upper extremity embolism from a subclavian aneurysm in a series of 95 patients while the majority of the patients developed emboli from the heart.¹⁰ Sachatelle reported 62 cases of upper extremity ischemia with only two subclavian aneurysms as the source for their emboli; one was associated with a cervical rib and the other with a false aneurysm. In the author's series, two of the three subclavian artery aneurysms presented with arterial embolization with the third being asymptomatic. Emboli of cardiac origin tend to be larger than those of arterial origin and therefore lodge more frequently in the brachial artery. On the other hand, embolic material of arterial origin is small and terminates in the vessels of the hands and fingers with typical findings of episodic pallor, cyanosis, paresthesias, coldness and pain. The differential diagnosis of small artery embolism may be difficult. One must distinguish between collagen vascular disease, vasospastic disorders, traumatic thrombosis and cardiac embolism. Symptoms may become progressive with propagation of thrombus to the larger proximal arteries.

The neurologic presentation of subclavian and axillary aneurysms is due to nerve compression, which produces a variety of symptoms including pain, tingling sensations, numbness, paresthesias and paresis. These symptoms may also be produced by leakage of blood from a false aneurysm causing brachial plexus irritation and encasement (exemplified by Case 3). In our own series, two of the four axillary artery aneurysms presented with pain from brachial plexus compression while the other two axillary aneurysms were asymptomatic.

Treatment—The management of subclavian and axillary artery aneurysms depends to a large extent on their etiology and associated complications. The primary goal is to exclude or resect the aneurysm. We prefer the latter technique employing interposition grafting with autologous saphenous vein if primary anastomosis is not possible. False aneurysms often are repairable by simple suture or patch grafting techniques. An infraclavicular approach is feasible for axillary aneurysms although supraclavicular control may be required for complex or large aneurysms. Large subclavian aneurysms may require an additional infraclavicular incision, clavicular resection and, in some instances, a median sternotomy or transthoracic approach.

In the thoracic outlet syndrome due to a cervical rib, deformed clavicle or anomalous first rib, decompression of the costoclavicular space can be achieved by rib or clavicular resection.

One of the major problems in the surgical management of subclavian or axillary artery aneurysms is the reestablishment of blood flow distally where distal embolic occlusion has occurred. Thromboembolectomy may be feasible via the operative site at the subclavian or axillary artery. Verification of the adequacy of this procedure should be obtained by intraoperative arteriography. Direct thromboembolectomy may be required. If a direct approach is not feasible or warranted, sympathetic denervation of the upper extremity should be considered, particularly in the presence of extensive thrombosis and long-standing ischemia.¹²

SUMMARY

Aneurysms of the subclavian and axillary arteries occur infrequently. Our experience with seven axillary and subclavian aneurysms in six patients over an eight-year period is documented. The etiology of these aneurysms is usually trauma and rarely atherosclerosis. The clinical presentation is either that of an asymptomatic pulsatile mass or more seriously, ischemia and even gangrene of the upper limb due to distal embolism from the aneurysm. Neurologic deficits may occur secondary to brachial plexus compression.

Urgent surgical intervention is required where advanced ischemia exists. Elective vascular reconstruction also should be undertaken to prevent the long-term sequelae of both pressure on the brachial plexus and distal emboli. Compressing osseous structures causing vascular lesions must be resected. Cervicothoracic sympathectomy should be performed as an adjunctive procedure in cases of extensive distal thrombosis or long-standing ischemia.

REFERENCES

1. Hobson RW, Sarkaria J, O'Donnell J, Neville W: Atherosclerotic aneurysms of the subclavian artery. *Surg* 85:368-371, 1979.
2. Natali V, Maraval M, Kieffer E: Arterial aneurysms of the upper extremities. *J Cardiovas Surg* 14 (Spec No): 291-296, 1973.
3. Mathes SJ, Salam AA: Subclavian artery aneurysm: Sequela of thoracic outlet syndrome. *Surg* 76:506-510, 1974.
4. Rich NM, Hobson RW, Jarstfer BS, Geer TM: Subclavian artery trauma. *J Trauma* 13:485-496, 1973.
5. Bjork VO: Aneurysm and occlusion of the right subclavian artery. *Acta Chir Scand* 356 (suppl):103-109, 1965.
6. Halsted WS: An experimental study of circumscribed dilation of an artery immediately distal to a partially occluding band and its bearing on the dilation of the subclavian artery observed in some cases of cervical ribs. *J Exp Med* 24:271-281, 1916.
7. Danese CA, et al: Recurrent embolism from 95 occult crutch aneurysms of the axillary artery. *Surg* 66:860-862, 1969.
8. Abbott WM, Darling RC: Axillary artery aneurysms secondary to crutch trauma. *Am J Surg* 125:515-520, 1973.
9. Heyden B, Vollmar J: Thoracic outlet syndrome with vascular complications. *J Cardiovas Surg* 20:531-536, 1979.
10. Baird RJ, Lajos TZ: Emboli to the arm. *Ann Surg* 160:905-909, 1964.
11. Sachatelle CR, Ernst CB, Griffin WD: The acutely ischemic upper extremity, selective management. *Surg* 76:1002-1009, 1974.
12. Whelan TJ, Banis JC, Rich NM: Ischemia of the upper extremity due to noncardiac emboli. *Am J Surg* 134:131-139, 1977.

Long-acting

Zaroxolyn[®]

(metolazone) Pennwalt

2½ mg, 5 mg, 10 mg tablets

***The only Step-1 diuretic
that can give you all of this...***



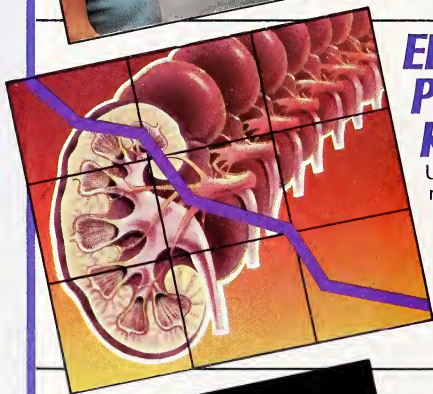
Long-acting
Zaroxolyn[®] (metolazone)
No other diuretic can



UNSURPASSED EFFECTIVENESS IN STEP-1 THERAPY

No other diuretic has proven superior in anti-hypertensive efficacy,¹⁻⁴ and in well-controlled studies^{1,5-9} of patients with mild to moderate hypertension (dBP 90-110 mm Hg):

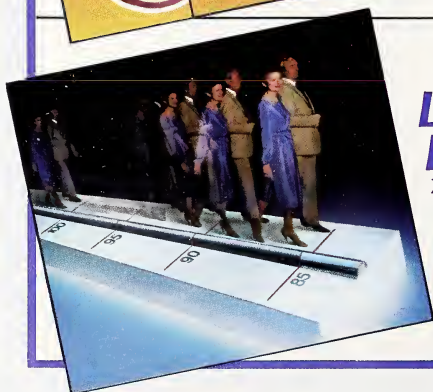
- ☐ 74% were normalized by Zaroxolyn alone (mean pretherapy dBP=102 mm Hg, mean posttherapy dBP=86 mm Hg)



EFFICACY IN THE PRESENCE OF REDUCED KIDNEY FUNCTION¹⁰⁻¹⁴

Unlike thiazides and chlorthalidone, Zaroxolyn may be effective in patients with GFR below 20 ml/min. And, unlike chlorthalidone, Zaroxolyn has a secondary effect in the proximal tubule.

Further, since kidney function decreases with age,¹⁵ Zaroxolyn is a rational choice for patients past the age of 40.



LONG-TERM EFFICACY

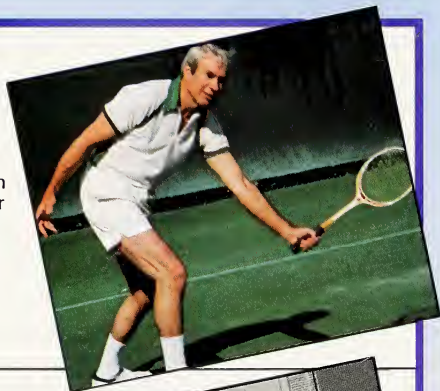
Zaroxolyn maintains efficacy over long periods without the development of tolerance. In patients with average pretherapy dBP of 115 mm Hg who were followed for 4 years, posttherapy dBP remained at a low 85 mm Hg with Zaroxolyn alone.^{1,7,8}

provide all these benefits

SAFETY

Clinically significant side effects are uncommon with Zaroxolyn therapy^{1,8}—usually no need for + supplementation.

And, because many patients are controlled on Zaroxolyn *alone*, they are spared the possibility of Step-2 side effects.



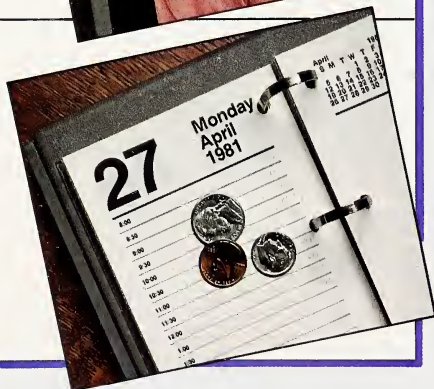
COMPLIANCE

Zaroxolyn has a 24-hour duration of action, permitting a single daily dosage.^{1,8} Control is smooth and sustained, with little nocturia or other interference with the patient's lifestyle. These factors enhance compliance,¹⁴ giving Zaroxolyn a very low dropout rate (4% due to side effects).¹



ECONOMY

Zaroxolyn is among the least expensive diuretics available.¹⁶ Zaroxolyn is a premium product at an affordable price—a product with distinct cost advantages.



Please see following page for prescribing information.

Long-acting
Zaroxolyn[®]
 (metolazone) Pennwalt
**Gives you what you
 want for more of your
 hypertensive patients**

- ☐ unsurpassed Step-1 effectiveness... maintained over the long run
- ☐ efficacy in the presence of reduced kidney function
- ☐ obviates the need for Step-2 drugs for many patients
- ☐ true once-daily dosage + minimal side effects = outstanding compliance
- ☐ long-term economy



Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients, dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may

occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasms, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension. In Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York: Stratton, 1976, pp 221-245. 3. Foltis S, Mroczek WJ, Davidow M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 4. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension. V. Comparison of hydrochlorothiazide with a new quinetha-

zone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 5. Van Hoesse MC, Cutler RE: Antihypertensive efficacy of metolazone (Zaroxolyn[®]) alone and combined with reserpine in treatment of essential hypertension. *Current Therapeutic Research* 20:266-276, 1976. 6. Cangiano JL, Campos JA, Trevino A, et al: The effects of metolazone in the long-term treatment of essential hypertension. *Current Therapeutic Research* 16:778-785, 1974. 7. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 8. Dorfheld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1976. 9. Materson BJ, Oster JR, Perez-Stable EC: Antihypertensive effects of metolazone (Zaroxolyn). *Current Therapeutic Research* 16:890-896, 1974. 10. Puschett JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 11. Craswell PW, Ezzat E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 12. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 13. Dargie HJ, Allison MEM, Kennedy AC, et al: Efficacy of metolazone in patients with renal edema. *Clin Nephrol* 2:157-160, 1974. 14. Anderson RJ, Hart GR, Lee DK: Pitfalls in management of essential hypertension: Diuretic therapy. Second in a series on antihypertensive drugs. *Primary Cardiology* 5:63-75, 1979. 15. Papper S. *Clinical Nephrology*. Boston, Little Brown & Co, 1971, p 17. 16. *Drug Topics Red Book* 1987.

PENNALT
 DIVISION
 ROCHESTER, NEW YORK 14623

Mucosal Biopsy in the Evaluation of Inflammatory Bowel Disease*

ROBERT R. RICKERT, M.D., Livingston

Mucosal biopsy has a major role in the diagnosis and management of inflammatory bowel disease. The differential features of the major forms of the disease, including ulcerative colitis and Crohn's Disease are emphasized and compared with less common disorders. Correlation with endoscopic and radiographic findings is stressed.

Mucosal biopsy has played an increasing role in the diagnosis and management of inflammatory bowel disease during the past 15 to 20 years. The introduction and increasing utilization of fiberoptic colonoscopy has broadened the use of biopsy in the assessment of these diseases.

Like most tissues, the large bowel mucosa responds in only limited ways to a variety of insults. Very few histologic changes are specifically diagnostic which accounts for the many diagnostic reports of "non-specific proctitis," "non-specific colitis" and "chronic inflammation."

When assessing biopsy material from patients suspected of having inflammatory bowel disease it is important to utilize all available information. Such an approach can lead to greater specificity and accuracy in diagnosis from biopsy specimens. Often overlooked is the critical importance of the gross as well as microscopic pathologic changes. For colonic and rectal biopsy the pathologist depends greatly upon the endoscopist for identification and interpretation of gross changes, which always should be communicated to the pathologist. The endoscopist, therefore, must learn to recognize patterns of gross alterations in the various inflammatory processes in order to select appropriate sites for biopsy. The finding "proctitis" as a gross description is not nearly as helpful to the pathologist as more meaningful terms such as friable, granular, ulcerative, fissured, congested, pseudomembranous or atrophic. These changes all have histologic counterparts of great diagnostic significance. As

with endoscopic findings, the clinical features are of great importance in the interpretation of biopsy material, especially when assessing the phase and level of activity of disease or the response to treatment.

This report will emphasize the role of mucosal biopsy in the diagnosis and management of the major categories of inflammatory bowel disease (ulcerative colitis, Crohn's disease and ischemic injury). The differential diagnostic features of these conditions as well as less common sources of diagnostic confusion will be reviewed.

NORMAL HISTOLOGY

The important question of whether or not the patient has inflammatory bowel disease cannot be addressed without an understanding of the spectrum of normal large bowel histology. The mucous membrane of the colon and rectum has a rather simple architecture. Straight gland tubules extend from the surface to abut on the muscularis mucosae (Figure 1). On the surface, tall absorptive cells are interspersed with the more numerous goblet cells while the deeper portions of the glands appear to consist almost entirely of goblet cells. Mitotic activity in normal mucosa is confined to the lower half of the glands. The supporting tissue of the mucosa, the

*Read before the Section on Gastroenterology and Proctology, 214th annual meeting of the Medical Society of New Jersey, May 12, 1980, Meadowlands Hilton, Secaucus. Dr. Rickert is Co-Director, Department of Pathology, St. Barnabas Medical Center, Livingston and Adjunct Associate Professor of Pathology, College of Physicians and Surgeons, Columbia University, New York.

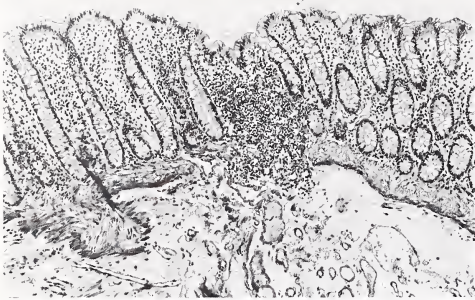


Figure 1—Normal colonic mucosa and submucosa with lymphoid follicle. Note straight and parallel gland tubules with numerous goblet cells (H&E x 198)

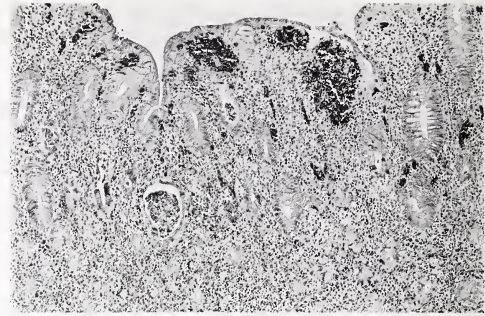


Figure 2—Rectal biopsy in acute ulcerative colitis. Note diffuse inflammation, congestion, focal hemorrhage and marked depletion of goblet cell population. A "crypt abscess" is at lower left. (H&E x 198)

lamina propria, contains capillaries and a few plasma cells, lymphocytes and rare eosinophils. Lymphoid follicles are normal in large bowel mucosa; their number tends to decrease with advancing age. Characteristically, they straddle and split the muscularis mucosae, extending slightly into the submucosa. Diffuse hyperplasia or lymphoid nodules extending deep into the submucosa are abnormal findings.

ULCERATIVE COLITIS

Ulcerative colitis is the prototype of inflammatory bowel disease. It is an inflammatory process of the mucosa of the rectum and a variable length of colon in continuity. The process generally is confined to the mucosa and sometimes superficial submucosa. Only when ulceration is marked or is associated with impending or established toxic dilatation does the process extend more deeply.

Selecting the biopsy site is generally not difficult since the rectum nearly always is involved. It should be remembered however, that mucosa which looks normal grossly may show typical though usually mild histologic changes. If the rectal mucosa appears grossly normal but ulcerative colitis is suspected, it should be biopsied. If the patient has ulcerative colitis, the biopsy probably will be histologically abnormal. If it is actually normal histologically, the patient probably does not have ulcerative colitis. An interesting and clinically important dividend of the increased use of colonoscopy is the observation that histologic evidence of disease frequently extends far more proximally than appreciated radiographically or endoscopically with the sigmoidoscope.

The individual histologic features of ulcerative colitis are not specific by themselves. The pattern of changes, however, especially if seen early in the attack, is virtually diagnostic¹ (Figure 2). The mucosa is congested and intensely inflamed; a diffuse increase in plasma cells and lymphocytes is most characteristic. Neutrophils, especially near degenerating tubules also are seen. Infiltration into tubules gives rise to the characteristic, though not diagnostic, "crypt abscess." Goblet cell depletion is a very important and characteristic feature of active ulcerative colitis.^{1,3} It occurs early and is one of the first changes to reverse in either spontaneous or therapeutically induced remission.

Remissions and exacerbations are common. A mild first attack may be followed by complete histologic resolution. Usually, however, some residue remains in the form of loss of gland parallelism, branching tubules or shortened tubules which no longer abut on the muscularis mucosae (Figure 3). In chronic, persistent disease, or in patients with incomplete

response to therapy, a variety of changes may occur. It is in these cases that clinical information is most important, especially when serial biopsies are being used to follow the course of disease and to evaluate the response to therapy. Without appropriate clinicopathologic correlation and review of prior biopsy material, one often cannot say more than "non-specific colitis." Paneth cell metaplasia is a frequent finding in long-standing colitis. In disease of long duration, which is clinically quiescent, there may be pronounced atrophy with marked thickening of the muscularis mucosae.

The risk factors which identify the patient most likely to develop carcinoma have been well documented.^{4,5} Of greatest importance are the duration and extent of disease. It now is recognized that carcinoma in ulcerative colitis develops in a background of precancerous dysplasia.^{6,9} This change is seen most commonly in the colons of patients with long-standing, total disease especially when onset was before 25 years of age (Figure 4). Several reports have described the usefulness of mucosal biopsy in the detection of this precancerous and cancer-associated abnormality.^{6,11} An important limitation is that interpretation of precancerous atypia is unreliable in the presence of marked inflammation because of the common occurrence of reactive atypia in active colitis. Although the rectum is the most common site, the changes also may be very patchy and occasionally spare the rectum.^{7,9} The increased use of colonoscopy with multiple biopsies has enhanced the use of this technique, since it eliminates the potential sampling problem. The likelihood of cancer in colons with dysplasia appears to increase with the severity of the atypical changes.¹⁰

CROHN'S DISEASE

The use of mucosal biopsy in the diagnosis of Crohn's disease is somewhat more complicated than in ulcerative colitis. Many of the important diagnostic features, such as fissuring ulceration and transmural inflammation, are better seen in the deeper bowel wall not sampled by biopsy.¹² The patchy nature of the inflammatory process also contributes to the sampling problem. When Crohn's disease is suspected, multiple biopsies should be made, submucosa must be included and grossly normal mucosa, if present, always should be sampled.

If fortunate, a sarcoid-type granuloma may be included in the biopsy specimen (Figure 5). Although this is the most specific diagnostic feature of Crohn's disease, it is not essential for diagnosis. A useful histologic finding is dis-

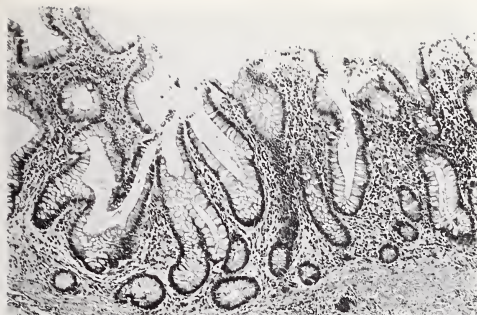


Figure 3—Rectal biopsy. Ulcerative colitis in clinical remission. Note irregularity of gland tubules with loss of parallelism and branching. (H&E x 198)

proportionate inflammation.¹³ This change, which is seen only when submucosa is sampled generously, consists of an intact but slightly inflamed mucosa overlying a more densely infiltrated submucosa (Figure 6). If submucosa is not included in the biopsy specimen, the mucosal appearance usually can be interpreted only as "non-specific." Preservation of the goblet cell population except at sites of ulceration is typical and contrasts with goblet cell depletion, which is characteristic of active ulcerative colitis.^{2,3} Another non-specific but helpful clue in Crohn's disease is patchy inflammation often associated with edema.

Patterns of ulceration from which a definitive diagnosis of Crohn's disease can be made in gross specimens or in full thickness sections only rarely are sampled by biopsy. Two distinctive patterns occur. One is the cleft-like fissuring ulcer which is the anatomic basis for many of the important complications of Crohn's disease, including sinus tracts, perforations and fistulae. The second characteristic ulcerated lesion is the minute "aphthoid" ulcer which grossly resembles the oral lesion of aphthous stomatitis. They are believed by some to be the earliest macroscopic lesion of Crohn's disease.¹⁴ Of special interest is their frequent demonstration in otherwise normal mucosa, often at a distance from more obvious gross disease.¹⁵ Their frequency and widespread distribution well may provide the "seeds" from which clinical recurrences arise. Histologically they frequently overlie hyperplastic lymphoid nodules. Although only rarely sampled in biopsy material, their appearance is highly suggestive of Crohn's disease.

ISCHEMIC INJURY

Mucosal biopsy of the large bowel usually is directed to the diagnosis and evaluation of patients thought to have either ulcerative colitis or Crohn's disease. However, we have observed in recent years an increase in examples of ischemic injury. Deprivation of the blood supply of the colonic mucosa leads to a variety of injury patterns which, though not basically inflammatory, may be clinically, radiographically and morphologically confused with the more common inflammatory diseases.¹⁶ Fortunately, the histologic appearance of ischemic injury, especially in the early stages, is usually characteristic. Correct diagnosis depends on clinical suspicion and early sampling of the lesion before secondary infection, sloughing or healing alter the appearance. The lesions are often patchy and may be edematous, hemorrhagic, ulcerative or membranous. They may resolve with marked rapidity. Although the splenic

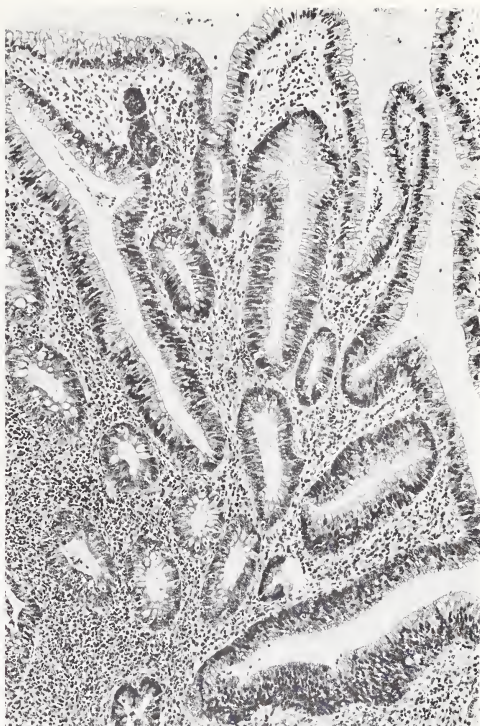


Figure 4—Precancer in ulcerative colitis of twenty years' duration. Note lateral branching and hypercellularity of gland tubules. (H&E x 198)

flexure is the most common site, the distal colon and, contrary to what is often written, the rectum also frequently are involved.¹⁷

The histologic features reflect the extent of ischemic injury. Superficial lesions often are covered by a mucopurulent "cap" and resolve rapidly. Full thickness mucosal infarction is the most characteristic lesion histologically (Figure 7). If damage is limited to the mucosa, resolution is usually complete and often rapid. Deeper involvement of the bowel wall may progress to full-thickness "gangrene" or, if healing occurs, lead to stricture formation.

PITFALLS AND MIMICS

There is a tendency to limit our diagnostic considerations to the disorders already discussed. Although the three conditions described will account for the majority of cases of inflammatory bowel disease evaluated by mucosal biopsy, other conditions may cause difficult problems in differential diagnosis and must be considered. Some of these are sufficiently distinctive to permit a definite diagnosis while others may closely simulate the so-called primary inflammatory bowel diseases.

A variety of infectious causes of acute and subacute diarrheal illness must be considered. Bacillary (Shigella) dysentery may produce histologic changes qualitatively very similar to ulcerative colitis (Figure 8). Often, however, there is a disparity between the gross (endoscopic) and microscopic appearances; the histologic findings usually are less dramatic than the history or endoscopic appearance suggests. Al-



Figure 5—Rectal biopsy in Crohn's disease. Granuloma present in mucosa (arrow). Note good preservation of goblet cell population of gland tubules. (H&E x 198)



Figure 6—Colonic biopsy in Crohn's disease showing disproportionate inflammation. Note that inflammatory infiltrate is more marked in submucosa. Mucosal glands and goblet cells are well preserved. (H&E x 198)

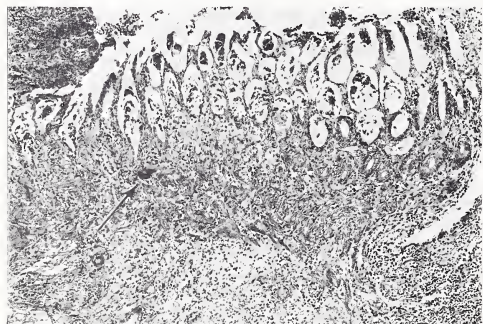


Figure 7—Rectal biopsy showing classical pattern of ischemic injury. Note extensive mucosal necrosis with necrotic cells sloughed into empty "ghost" tubules. Microthrombi are seen in mucosal capillaries (arrow). Submucosa is edematous with focal hemorrhage. (H&E x 198)



Figure 8—Rectal biopsy in acute bacillary dysentery (shigellosis). Mucosa is congested. Although there is moderate goblet cell depletion, the diffuse inflammation seen in ulcerative colitis is lacking. (H&E x 198)

though there may be goblet cell depletion as in ulcerative colitis, the characteristic diffuse inflammatory infiltration of plasma cells and lymphocytes is usually less. When infiltration by neutrophils is present it is more diffuse than in ulcerative colitis.

Salmonella infection of the food-poisoning type also may be associated with acute colitis.¹⁸ The changes are usually non-specific and consist of mucosal edema and varying degrees of acute inflammation. As with *Shigella* dysentery, the changes are usually distinctive enough to distinguish

from ulcerative colitis and Crohn's disease. However, because similar non-specific changes also may be seen in treated or resolving ulcerative colitis and Crohn's disease, clinical findings including careful endoscopic examination and microbiologic studies are necessary for definitive diagnosis.

More recently, *Campylobacter fetus* ss. *jejuni* has been recognized as a common human enteric pathogen which may cause an acute colitis.¹⁹ The changes are similar to those of bacillary dysentery, and, when severe and accompanied by

goblet cell depletion, may simulate acute ulcerative colitis.

One always should be alert for the possibility of amoebas, especially when a discrete ulcer is noted on the biopsy. The parasites are seen best in the overlying mucoid exudate or adjacent to an ulcer.

There have been numerous reports of the association of acute pseudomembranous colitis with the administration of antibiotics, especially lincomycin and clindamycin. The colitis may be difficult to distinguish clinically and radiographically from ulcerative colitis and Crohn's disease. The pathologic features of the well-developed lesions are usually quite distinctive.²⁰ Very early lesions, however, may be quite non-specific and the late lesion may be impossible to distinguish from acute ischemic injury. This emphasizes again the need for careful history and recognition of the typical endoscopic appearances so that properly directed and timely biopsies are performed.

An interesting condition which may be confused with long-standing or quiescent ulcerative colitis is the "cathartic" colon.²¹ The radiologic appearance also may suggest chronic ulcerative colitis although the changes usually are most pronounced in the right colon. The typical gross appearance is a grey-brown mucosa with a texture much like leather. The histologic appearance may be similar to quiescent ulcerative colitis. The muscularis mucosae often is thickened markedly. There are no destructive epithelial changes, however, and true atrophy usually is not seen. "Melanosis" almost always is present. Biopsy specimens from cases of "cathartic" colon probably will be more common as the use of fiberoptic colonoscopy increases.

SUMMARY

The differential histologic diagnosis of inflammatory bowel disease based on mucosal biopsy specimens may be difficult. In spite of the frequent overlap of histologic features, accurate diagnosis is usually possible when all the clinical, radiologic, endoscopic and histologic findings are considered and correlated. Communication between the involved physicians from all contributing disciplines is essential to provide the host accurate interpretations of the biopsy material.

REFERENCES

1. Morson BC: Pathology of ulcerative colitis. *Proc R Soc Med* 64:976-977, 1971.
2. Hellstrom HR, Fisher ER: Estimation of mucosal mucin as an aid in the differentiation of Crohn's disease of the colon and chronic ulcerative colitis. *Am J Clin Pathol* 48:259-268, 1967.
3. Filipe MI, Dawson I: The diagnostic value of muco-substances in rectal biopsies from patients with ulcerative colitis and Crohn's disease. *Gut* 11: 229-234, 1970.
4. Morson BC: Cancer in ulcerative colitis. *Gut* 7:425, 1966.
5. Hinton JM: Risk of malignant change in ulcerative colitis. *Gut* 7:427-432, 1966.
6. Morson BC, Pang LSC: Rectal biopsy as an aid to cancer control in ulcerative colitis. *Gut* 8:423-434, 1967.
7. Myrvold HE, Kock NG, Ahren C: Rectal biopsy and pre-cancer in ulcerative colitis. *Gut* 15:301-304, 1974.
8. Yardley JH, Keren DF: "Precancer" lesions in ulcerative colitis: A retrospective study of rectal biopsy and colectomy specimens. *Cancer* 34 (Suppl):835-844, 1974.
9. Cook MC, Goligher JC: Carcinoma and epithelial dysplasia complicating ulcerative colitis. *Gastroenterol* 68:1127-1136, 1975.
10. Nugent FW, Hagitt RC, Colcher H, Kutteruf GC: Malignant potential of chronic ulcerative colitis: Preliminary report. *Gastroenterol* 76:1-5, 1979.
11. Riddell RH, Morson BC: Value of sigmoidoscopy and biopsy in detection of carcinoma and premalignant change in ulcerative colitis. *Gut* 20:575-580, 1979.
12. Lockhart-Mummery HE, Morson BC: Crohn's disease (regional enteritis) of the large intestine and its distinction from ulcerative colitis. *Gut* 1:87-105, 1960.
13. Dyer NH, Stansfeld AG, Dawson AM: The value of rectal biopsy in the diagnosis of Crohn's disease. *Scand J Gastroint* 5:491-496, 1970.
14. Morson BC: The early histological lesion of Crohn's disease. *Proc R Soc Med* 65:71-72, 1972.
15. Rickert RR, Carter HW: The "early" ulcerative lesion of Crohn's disease: Correlative light and scanning electron microscope studies. *J Clin Gastroenterol* 2:11-19, 1980.
16. Whitehead R: The pathology of intestinal ischemia. *Clin Gastroenterol* 3:613-637, 1972.
17. Kilpatrick ZM, Farman J, Yesner R, et al: Ischemic proctitis. *JAMA* 205:74-80, 1968.
18. Day DW, Mandal BK, Morson BC: The rectal biopsy appearances in Salmonella colitis. *Histopathol* 2:117-131, 1978.
19. Blaser MJ, Parsons RB, Wang WL: Acute colitis caused by *Campylobacter fetus* ss. jejuni. *Gastroenterol* 78:448-453, 1980.
20. Price AB, Davies DR: Pseudomembranous colitis. *J Clin Path* 30:1-12, 1977.
21. Whitehead R: *Mucosal Biopsy of the Gastrointestinal Tract*. London, Saunders, 1973, p. 181-183.

WE PUT YOUR REAL ESTATE INVESTMENT DOLLARS TO WORK FOR YOU!

Your best investment may be purchasing a condominium unit for rental purposes. We can find that exact investment property—the one that best suits your individual needs—no matter where it might be in the United States.

All across the nation, we search for condominium conversions and newly-constructed condominiums especially suitable for investment purposes. We research each project, then make our recommendations to you. Because we're there at the conception of the conversion or construction, you buy the properties at the original and lowest prices.

- We arrange for the purchase of the condominium
- We aid in obtaining your financing
- We carefully screen and find tenants for your condominium
- We arrange management of the unit for you
- WE SEE THAT YOUR DOLLARS ARE WORKING FOR YOU!

We handle the investment transaction from beginning to end. And as your representative, we minimize the responsibilities of ownership. You just enjoy the advantages:

- 100% ownership
- Appreciation of investment unit
- Obvious tax breaks—depreciation on rental property, interest and property tax deductions
- At sale, your profit is capital gains, not ordinary income

Write or call Skyline Associates for more information. A representative will contact you with everything you need to know about our services.

Skyline Associates, Inc.
72 Hickory Road
Ringwood, New Jersey 07456
201/962-6300

Please contact me with additional information about condominium investments and the services you provide.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

COMPARE OUR PREMIUM RATES!

\$500,000

ANNUAL RENEWABLE & CONVERTIBLE TERM INSURANCE

Age	Initial Premium
35	\$ 595
40	795
45	1,110
50	1,595
55	2,480
60	3,845

Minimum policy \$100,000

CALL OR HAVE
YOUR BROKER CALL

N.Y.C.

(212) 687-0031

N.J.

(201) 947-3100



THE INSURANCE
SUPERMARKET, INC.
RIDGEFIELD, N.J. 07657

CASE REPORTS

Aortic Dissection: A Rare Cause of the Superior Vena Cava Syndrome*

DAVID J. RILEY, M.D., ROGER T. LIU, M.D.,
SEYMOUR SAXANOFF, M.D., Piscataway

Two cases of superior vena cava (SVC) syndrome caused by dissecting atherosclerotic aortic aneurysms are reported and the clinical and radiographic features are reviewed. This entity rarely is seen; only eight other cases have been reported in the literature.

The superior vena cava syndrome (SVC) is manifest by dilation of the veins of the upper part of the body and swelling and cyanosis of the head, neck, and arms. Malignancy is the cause of the syndrome in 97 percent of cases; non-malignant disorders, such as mediastinal fibrosis, goiter and thrombosis of the SVC, cause the other three percent of cases.¹ Atherosclerotic aortic aneurysm as a cause of the SVC syndrome is rare; eight cases have been reported in the literature.²⁻⁹ We report two additional cases and emphasize the clinical and radiographic features which might suggest an aneurysm as the cause of the SVC syndrome.

CASE REPORTS

Case 1—A sixty-one-year-old male noted a sudden dull, aching pain in the left anterior chest followed by a syncopal episode. Examination showed a blood pressure of 90/70 mm Hg in both arms, pulse 116, respirations 20, and temperature 37°C. The veins of both arms and the neck were distended and did not collapse; there was no evidence of collateral venous flow. Swelling and cyanosis of the neck, face and arms were noted. Evidence of an effusion was present at the left base. A grade 3 of 6 systolic ejection murmur at the left sternal border was the only cardiac abnormality. The venous pressure in the right arm was 20 cm H₂O and was 11 cm H₂O in the femoral vein.

A roentgenogram of the chest showed a left suprahilar mass, mediastinal widening, and a large left pleural effusion.

The VDRL was negative. Bloody pleural fluid was found on thoracentesis. Bronchoscopic examination showed extrinsic compression of the trachea and left mainstem bronchus. A venacavagram showed almost complete obstruction of the SVC at the level of the brachiocephalic veins (Figure 1). Bronchogenic carcinoma was suspected, but because the hematocrit had dropped from 40 percent on admission to 28 percent on the third hospital day, a leaking aneurysm was considered. Retrograde catheterization of the aorta followed by arteriography showed dissecting aneurysm of the thoracic aorta originating just distal to the left subclavian artery and extending to the celiac artery. The opaque material was seen entering the false channel and displacing the trachea and the brachiocephalic arteries (Figures 2 and 3).

At surgery, the aorta was found to have ruptured near the origin of the left subclavian artery. A 700 ml hematoma compressed the SVC and left subclavian vein, accounting for the suprahilar mass. Blood had dissected into the left pleural space and around the trachea and left main bronchus. The aorta, which was markedly atherosclerotic, was resected

*From the Pulmonary Disease Division, Department of Medicine and Radiology, Rutgers Medical School, CMDNJ. This work was supported in part by a Pulmonary Academic Award (HL 00443) from the Division of Lung Diseases, National Heart, Lung and Blood Institute, National Institutes of Health (Dr. Riley). Correspondence may be addressed to Dr. Riley, Department of Medicine, Raritan Valley Hospital Unit, Rutgers Medical School, 275 Greenbrook Road, Green Brook, NJ 08812.



Figure 1—Superior venacavagram of Case 1 demonstrating obstruction to venous inflow at the level of the brachiocephalic vein (arrow) and displacement and obstruction of mediastinal collateral veins.

from the left subclavian artery to the celiac artery and was replaced with a graft. Venous obstruction was not evident postoperatively. The patient died a week later of hepatic failure and permission for autopsy was denied.

Case 2—A seventy-five-year-old man was well until sudden, knife-like anterior chest pain occurred followed by the appearance of venous distension and swelling of the neck, head, and arms. On examination he was critically ill. Blood pressure was 100/65 mm Hg in both arms, pulse 100, respirations 20, and temperature 37.5°C. His upper extremities, neck, and face were swollen and cyanotic; there was no evidence of venous collaterals. The cardiac examination was normal. The venous pressure was 25 cm H₂O and 8 cm H₂O in the left leg. A chest roentgenogram showed mediastinal widening.

Carcinoma was suspected as the cause of the SVC syndrome and no diagnostic studies were done. He was stabilized with digitalis and diuretics, but on the third hospital day severe chest pain recurred and venous distension, cyanosis and swelling of the head and neck worsened. Ventricular fibrillation occurred and he expired.

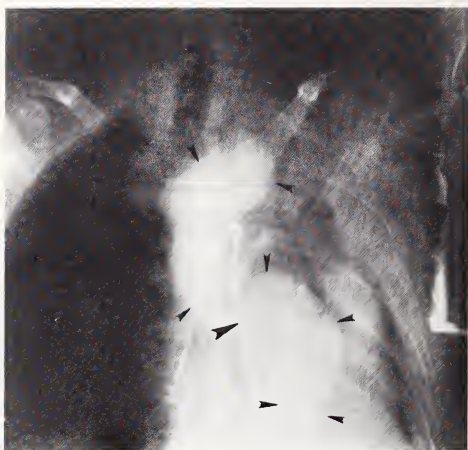
Autopsy showed a large aneurysm involving the aortic root. A tear was located 2 cm. above the aortic valve, and dissection had occurred retrograde toward the root with bleeding into the pericardial sac. In addition, there was a large hematoma compressing the SVC.

DISCUSSION

The presenting clinical features and chest roentgenogram findings of a thoracic aneurysm may be varied and create a confusing picture. Aneurysms may cause symptoms by compressing thoracic structures, or the aneurysm may be discovered by roentgen examination of an asymptomatic patient. If the aneurysm dissects through the media of the vessel, a double-barrel lumen is created. The dissection may extend proximally to involve the aortic valve and cause aortic insufficiency. Interference with blood supply to the brain or



A



B

Figure 2—Frontal views of aortogram of Case 1. (A) Early phase of aortogram demonstrating dissecting aneurysm. The contrast material is seen in the true channel of the descending aorta which is compressed (arrows). (B) Late phase of same study demonstrating contrast material in the false channel (small arrows). The catheter is positioned in the true channel (large arrow).

spinal cord could lead to neurologic symptoms, or the dissection may involve the coronary vessels leading to myocardial ischemia. A rupture through the adventitia can cause rapid enlargement of a mediastinal mass or the sudden appearance of blood in the pleural space or pericardium.

Our two cases and those previously reported²⁻⁹ illustrate that a thoracic aortic aneurysm can cause the SVC syndrome. Furthermore, the picture can be confused with



Figure 3—Lateral view of the mid-phase of the aortogram of Case 1. Contrast material is seen leaking into the false channel (arrows) which is displacing the brachiocephalic vessels and trachea forward (asterisks).

malignancy, the most common cause of the SVC syndrome.¹ This was evident in Case 1; the presence of a suprahilar mass, bloody pleural effusion, and extrinsic compression of the tracheobronchial tree suggested neoplasm as the cause of the SVC syndrome. Case 2 was assumed to have malignancy as the cause of the SVC syndrome. These cases illustrate that attention to the mode of onset of the SVC syndrome can provide clues which might favor aneurysm rather than neoplasm as the cause of the SVC syndrome. Obstruction typically develops within minutes to hours in patients with aortic aneurysms; obstruction due to cancer takes days to weeks to develop. Dilated venous collaterals on physical examination of the chest usually are not evident in the cases caused by aneurysm whereas in obstruction due to malignancy there usually is sufficient time to allow for opening of venous collaterals. Syncope and chest pain often precede the development of the SVC syndrome in patients with aneurysms. Cerebral edema leading to disturbed states of consciousness occur only in advanced stages of obstruction due to malignancy. Finally, signs of acute blood loss may suggest the diagnosis of a leaking aortic aneurysm.

There are several ways in which an aortic aneurysm may obstruct venous inflow into the heart and cause the SVC syndrome: the aneurysm may directly compress the SVC;^{2-4,8} a hematoma may form around the SVC;⁷ and the aneurysm may leak into the pericardial space and cause tamponade.⁴ In addition, a fistula may form between the ruptured aortic aneurysm and the SVC to impede venous return.⁴

The primary therapeutic approach to the SVC syndrome is

palliative radiotherapy. Extensive diagnostic evaluation generally is not recommended since invasive procedures such as mediastinoscopy may be potentially dangerous and the possibility of finding a non-malignant cause of the obstruction is small.¹ However, the present report emphasizes the need to search for aortic aneurysm when the symptoms and signs mentioned above are present. If an aneurysm is suspected, a definitive diagnosis can be made only by means of contrast visualization. This may reveal the characteristic findings of irregular narrowing of the main channel, often associated with widening of the aorta, and less commonly the false channel may be demonstrated.¹⁰ However, the angiographic findings can be misleading. Shuford *et al.* reported that initial views of four of 22 angiograms of patients with documented aneurysms were found to have normal studies and additional views were needed to demonstrate the aneurysm.¹¹ There is a difference of opinion about whether transvenous arteriography or retrograde arteriography is the preferred technique for demonstrating a dissecting aneurysm. Dinsmore advises a flexible approach based on the clinical situation.¹²

SUMMARY

The two cases reported here illustrate that the mode of onset of the SVC syndrome caused by a dissecting aneurysm may differ from the mode of onset of the SVC syndrome caused by malignancy. The features which might suggest an aneurysm as the cause of SVC syndrome are: rapid onset of obstruction, absence of venous collaterals, and the presence of syncope, chest pain, cerebral symptoms, or signs of acute blood loss. If these features are present, contrast arteriography should be done to verify the presence of a dissecting aneurysm.

REFERENCES

1. Lokich JJ, Goodman R: Superior vena cava syndrome. Clinical management. *JAMA* 231:58-61, 1975.
2. Baker LA: Dissecting aneurysm of the aorta with complete obstruction of the superior vena cava. *Med Bull Vet Adm* 17:170-174, 1940.
3. Emery WF: Dissecting aneurysm, with an account of twenty-four cases. *Med J Aust* 2:690-698, 1946.
4. Calenda DG, Uricchio JF: Superior vena cava syndrome. Differentiation between simple obstruction and aorticocaval communication. *Arch Intern Med* 91:800-807, 1953.
5. Urschel HC Jr., Paulson DL: Superior vena cava syndrome. *Dis Chest* 49:155-164, 1966.
6. Banker VP, Maddison FE: Superior vena cava syndrome secondary to aortic disease. Report of two cases and review of the literature. *Dis Chest* 51:656-662, 1967.
7. Strax TE, Ryvicker MJ, Elguezal A: Superior vena cava syndrome due to mediastinal hematoma secondary to a dissecting aortic aneurysm. *Dis Chest* 55: 338-341, 1969.
8. Spitzer S, Blanco G, Adam A, Spyrou PG, Mason D: Superior vena obstruction and dissecting aortic aneurysm. *JAMA* 233:164-165, 1975.
9. Mahajan V, Strimlan V, Van Ordstrand HS, Loop FD: Benign superior vena cava syndrome. *Chest* 68:32-35, 1975.
10. Hemley SD, Kanick V, Kittredge RD, Finby N: Dissecting aneurysms of the thoracic aorta. Their angiographic demonstration. *Amer J Roentgen, Radium Therapy and Nuclear Med* 91:1263-1287, 1964.
11. Shuford WH, Sybers RG, Weons HS: Problems in the aortographic diagnosis of dissecting aneurysms of the aorta. *N Engl J Med* 280:225-231, 1969.
12. Dinsmore RE: Angiography for dissecting aneurysm of the aorta. *N Engl J Med* 280:272, 1969.

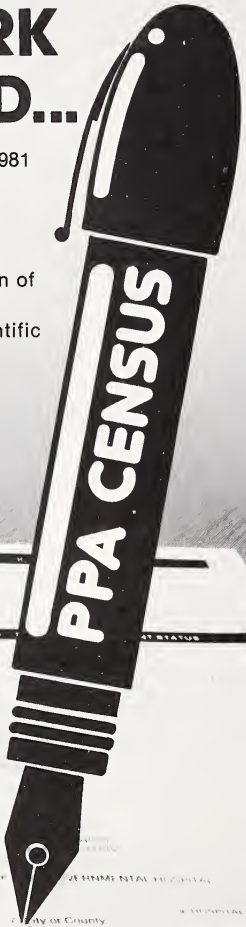
MAKE YOUR MARK AND BE COUNTED...

If you haven't already, now is the time to complete the 1981 Census of Physicians' Professional Activities.

Doing so will assure:

- that your official record is updated
- that you are accurately represented in the 28th Edition of the *American Medical Directory*
- that you continue to receive the educational and scientific materials relevant to your professional interests

Call or write if you have not received a census form
Division of Survey & Data Resources
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
312-751-6435



1. How many hours per week do you spend on DIRECT CARE OF PATIENTS?

2. How many hours per week do you spend on ADMINISTRATIVE ACTIVITIES as a Salariat Staff Member or as a Consultant?

3. How many hours per week do you spend on MEDICAL TEACHING?

4. How many hours per week do you spend on OTHER MEDICAL ACTIVITIES (not listed above) involving DIRECT CARE OF PATIENTS?

5. How many hours per week do you spend on OTHER MEDICAL ACTIVITIES (not listed above) not involving care of patients?

6. About how many hours per week do you spend in ALL PROFESSIONAL ACTIVITIES? For Residents this is the total of questions 1, 2 and 3. For all other physicians this is the total of questions 1-5.

7. The TOTAL in question 6 above is 20 hours or less. Please answer question 9.

8. Indicate Federal Agency:

9. OTHER ORGANIZATION —

10. Retired 2 Semi-retired 3 Permanently Disabled temporarily not in practice or active for other reasons (please describe)

Total of Section I equivalent to total of Section II and total of Section III respectively

Aneurysm of the Pancreaticoduodenal Artery

ELPIDIO C. MARIANO, M.D. and
RALPH S. GRECO, M.D., Piscataway

Spontaneous hemorrhage from a ruptured pancreaticoduodenal artery aneurysm is a rare and catastrophic disease requiring urgent intervention. Since the clinical picture may mimic many common gastrointestinal diseases, diagnosis, treatment and patient survival will depend upon the physician's high index of suspicion and the availability of diagnostic modalities such as angiography. An illustrative case is reported.

Spontaneous hemorrhage from ruptured pancreaticoduodenal artery aneurysm is a rare and catastrophic disease requiring urgent intervention. Recently splanchnic angiography has been used to diagnose this condition prior to operation.¹ However, if such aneurysms rupture into the free peritoneal cavity, the patients usually are in shock and their condition may not permit tedious diagnostic techniques. In addition, the clinical picture may be confused when these patients have symptoms prior to hemorrhage which mimic common gastrointestinal diseases not requiring angiography. Our case report illustrates management problems as well as the role of splanchnic angiography.

REPORT OF A CASE

A 67-year-old female, who had been in excellent health all her life, was treated with Butazolidine® because of shoulder pain beginning five days prior to admission. On the day of her admission she noted the gradual onset of severe abdominal pain and vomiting. Physical examination revealed a rigid abdomen with tenderness in the upper mid-epigastrium. Her blood pressure was 100/60 and she felt syncopal on standing. Her white blood count was 12,000 per cmm and hematocrit was 30 percent. Other laboratory tests were within normal limits. An upright abdominal roentgenogram showed a radiolucency in the left upper quadrant suggesting a pneumoperitoneum (Figure 1). The diagnosis of gastrointestinal perforation was made; treatment was begun with

intravenous fluids and antibiotics and the patient was prepared for transfer to the operating room. During this period, her blood pressure returned to normal.

Surgical exploration revealed a massive hemoperitoneum with a retroperitoneal hematoma extending into the small bowel mesentery. A tear in the posterior peritoneum above the small bowel mesentery revealed arterial bleeding which was controllable by pressure. However, this approach did not allow access to the bleeding vessel. Therefore, the aorta was cross-clamped at the hiatus. The right colon was mobilized in its entirety, as was the duodenum. A very large pulsatile vessel could be felt behind and within the pancreas, and bright red bleeding was coming from the lower border of the pancreas above the duodenum. This was controlled with multiple arterial sutures through the vessel and the pancreatic tissue. Aortic cross-clamping was discontinued after twenty minutes.

The patient's postoperative course was completely unremarkable. A visceral arteriogram was performed on the ninth postoperative day (Figure 2). This revealed a single, large superior mesenteric artery without a celiac or inferior mesenteric artery present. A large tortuous vessel originating from the superior mesenteric supplied the pancreatic arcades, the gastroduodenal, the hepatic and the splenic arteries.

This report is from the Department of Surgery, CMDNJ-Rutgers Medical School. Correspondence may be addressed to Dr. Mariano, Department of Surgery, CMDNJ-Rutgers Medical School, P.O. Box 101, Piscataway, NJ 08854.



Figure 1—Upright abdominal roentgenogram. Arrow points to a radiolucency under the left diaphragm.

Bleeding (to the left of the hemoclips, in Figure 2) was from a branch of this large blood vessel.

COMMENT

The pathogenesis of spontaneous hemorrhage from ruptured pancreaticoduodenal aneurysm has not been established fully. Although traumatic dissection and medial degeneration have been implicated, they occur to a great extent in older patients with peripheral atherosclerosis.² Baum *et al.* have shown that when atherosclerotic occlusive disease involves the celiac axis, the pancreaticoduodenal arcade becomes progressively larger as the upper abdominal viscera become increasingly dependent upon it for survival.³ It can be assumed that progressive increase in diameter of the vessel leads to aneurysmal formation and eventual rupture. Spanos *et al.* have concluded that the risk of rupture of visceral aneurysms is greater when the diameter of the vessel reaches three to four times the original size.¹

Diagnosis is difficult because of lack of pathognomonic signs and symptoms. In a recent review of these cases, nonspecific abdominal pain is the most common complaint.² Rupture of the aneurysm eventually leads to shock, but symptoms precede frank rupture in nearly every case. In our patient, shoulder pain was present for five days. Bleeding



Figure 2—Postoperative selective superior mesenteric arteriogram. Bleeding (arrow to the left of the hemoclips) was from a branch of the tortuous pancreaticoduodenal arcade.

occurs most commonly into the retroperitoneal or intraperitoneal space and rarely into the pancreatic duct or gastrointestinal tract. Since symptoms precede catastrophic hemorrhage, Verta has concluded that diagnostic techniques can be employed.² Sweetman has proposed selective celiac and superior mesenteric angiography in patients with pain, hemorrhage and shock, the origin of which is not detectable by conventional means, and in patients with right upper quadrant calcification, or an unexplained mass or bruit.⁴

It has been shown, however, that four of five patients with splanchnic artery aneurysm seek medical attention at the time of rupture and it is not always practical to take time for a full angiographic study.⁵ Once surgical exploration has been performed and a large retroperitoneal hematoma of obscure origin is noted, intraoperative arteriography can be done to define the origin of the hemorrhage. When the aneurysm has been identified, operative management is straight forward. These lesions generally may be managed by simple ligation, with or without excision, thus avoiding injury to the pancreas.⁶ There is usually no need to re-establish arterial continuity.

Ruptured pancreaticoduodenal aneurysm carries a 50 percent mortality. However, a trend toward improving survival rate recently has been attributed to more aggressive preoperative management and surgical treatment aided by preoperative or intraoperative visceral angiography.²

It is to be expected that asymptomatic pancreaticoduodenal aneurysms will be found with increasing frequency as visceral angiography is used more in the diagnosis of obscure gastrointestinal symptoms. Elective ligation, with or without resection of these lesions, should be performed to avoid the grave risk of rupture, massive hemorrhage and death.

"The pathogenesis of spontaneous hemorrhage from ruptured pancreaticoduodenal aneurysm has not been established. . ."

"... nonspecific abdominal pain is the most common complaint. Rupture of the aneurysm eventually leads to shock, but symptoms precede frank rupture in nearly every case."

SUMMARY

Spontaneous hemorrhage from ruptured pancreaticoduodenal artery aneurysm is a rare and catastrophic disease requiring urgent intervention. Recently, splanchnic angiography has been used to diagnose this condition prior to operation. However, in the face of rupture into the free peritoneal cavity, patients usually are in shock and their condition may not permit tedious diagnostic techniques. In addition, a large number of these patients have symptoms for a period of time prior to hemorrhage which mimic far more common gastrointestinal diseases not requiring angiography. A case is reported which illustrates the difficulties in arriving at a definite diagnosis. The role of visceral angiography, preoperative or intraoperative, in identifying the aneurysm is emphasized. Since these lesions usually can be managed by simple ligation, it is hoped that as more visceral aneurysms are found in the diagnosis of obscure gastrointestinal symp-

toms, elective operations can be done to avoid the grave risk of rupture, massive hemorrhage and death.

REFERENCES

1. Spanos PK, Kloppedal EA, Murray III CA: Aneurysms of the gastroduodenal and pancreaticoduodenal arteries. *Am J Surg* 127:345-348, 1974.
2. Verta MJ, Dean RH, Yao JST *et al*: Pancreaticoduodenal arterial aneurysms. *Ann Surg* 186:111-114, 1977.
3. Baum S, Stein GN, Bav A: Extrinsic pressure defects on the duodenal loop in mesenteric occlusive disease. *Radiol* 85:866-874, 1965.
4. Sweetman, WR, Weinstein JJ: Hepatic and celiac artery aneurysms. *JAMA* 197:221-223, 1966.
5. West JE, Bernhardt H, Bowers RF: Aneurysms of the pancreaticoduodenal artery. *Am J Surg* 115:835-839, 1968.
6. Stanley JC, Thompson NW, Fry WJ: Splanchnic artery aneurysms. *Arch Surg* 101:689-697, 1970.

Diagnosis: obsolete patient billing procedures

Treatment: Universal Billing Systems

If your billing procedures haven't kept pace with your practice, it's time to talk to Universal Billing Systems. At Universal, we're specialists in computerized billing for the medical profession. Whether you're a solo practitioner or part of a group or clinical practice, we can customize a low-cost billing system to meet your exact needs. And we do it all! We print monthly statements and mail them directly to your patients. (The payments come to **you!**) We provide you with up-to-date **weekly** activity reports. Even eliminate the need for filling out time-consuming 3rd-party insurance forms. Universal Billing Systems can

- reduce labor costs
- increase billing efficiency
- speed cash flow
- eliminate billing delays caused by photocopying of bills and statements
- bring your patient billing system into the 80's

Best of all, your patients receive full details of every transaction including types of services rendered and types of payments received. This greatly reduces telephone inquiries to your office. And . . . your medical assistants require no special training to submit billing data to Universal. Write or phone for full details!



UNIVERSAL BILLING SYSTEMS

4 BANTA PLACE • HACKENSACK, N.J. 07601 • 487-8636

Amenorrhea: The Modern Office Evaluation

MARCO A. PELOSI, M.D., New Providence*

Recent knowledge of amenorrhea enables the primary care physician to make an accurate diagnosis when a rational strategy is followed. A simple, modern scheme for the differential diagnosis of amenorrhea, utilizing procedures available to all physicians, is presented.

Amenorrhea, which is the complete absence of menstruation during the reproductive span of life, traditionally has been classified as primary or secondary in nature. Primary amenorrhea refers to failure of the menarche to occur by the eighteenth year of life. In the United States, the menarche occurs between the ages of twelve and fifteen. Preceded by development of the secondary sex characteristics, it ordinarily follows a rather precise time-table. Secondary amenorrhea refers to the cessation of uterine bleeding in patients who previously have menstruated.^{1,2}

Any patient fulfilling the following criteria has this clinical problem:³

1. Menstruation has not occurred by age fourteen and it is apparent that development of the secondary sexual characteristics is absent or retarded.

2. Menstruation has not occurred by age sixteen despite normally developing sexual characteristics.

3. A patient has not menstruated for a period equivalent to three of her normal menstrual cycles, or when amenorrhea has persisted for six months.

The diagnostic evaluation and clinical management of patients experiencing primary or secondary amenorrhea are analogous, therefore, the classical distinctions are no longer necessary. The modern evaluation of the patient with amenorrhea applies to all such patients. Premature categorization may lead to diagnostic omissions and to unnecessary and expensive diagnostic procedures in some instances.

Moreover, emphasis should be directed toward certain physiologic conditions associated with amenorrhea: postmenarchal, premenopausal, pregnancy, puerperium and lactation states.

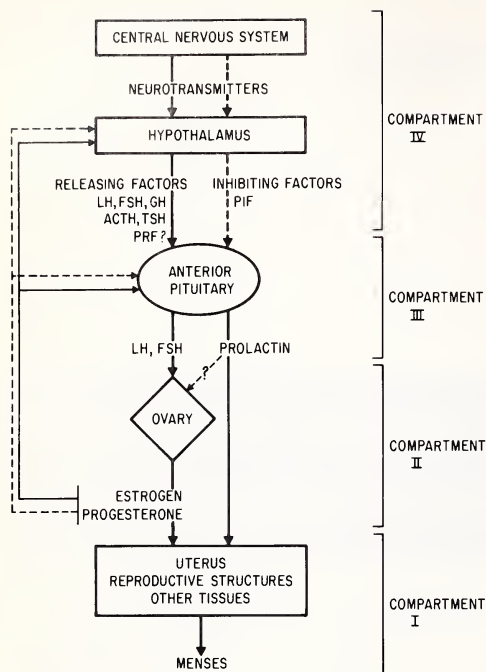
A brief review of the normal and abnormal physiology of menstruation will clarify the diagnostic evaluation (figure 1). The normal menstrual cycle requires an exact synchrony in the function of all endocrine glands and their target organs, as well as the hypothalamus and other central nervous system centers. Disturbed function anywhere in the hypothalamic-pituitary-ovarian-uterine axis, with or without an associated organic lesion, may result in the absence of menstrual function. The extreme diversity of the causes of this clinical symptom is acknowledged¹⁻⁷ (table 1).

GENITAL OUTFLOW TRACT

Menstruation requires an intact genital outflow tract. The vaginal orifice, the vaginal canal, the cervical canal, and the uterine cavity must be patent with proper continuity present. The presence of the menstrual flow depends on the existence and adequate development of the endometrium.

*Dr. Pelosi is Clinical Associate Professor, Department of Obstetrics and Gynecology, CMDNJ, New Jersey Medical School, and Clinical Associate Professor, Department of Obstetrics and Gynecology, Hahnemann Medical College of Philadelphia. Dr. Pelosi may be addressed at 47 Penwood Drive, New Providence, NJ 07974.

Figure 1



=====	EXCITATORY STIMULUS
=====	INHIBITORY STIMULUS
LH	LUTEINIZING HORMONE
FSH	FOLLICLE STIMULATING HORMONE
GH	GROWTH HORMONE
ACTH	ADRENOCORTICOTROPIC HORMONE
TSH	THYROID STIMULATING HORMONE
PRF	PROLACTIN RELEASING FACTOR
PIF	PROLACTIN INHIBITING FACTOR

Table 1
Causes of Amenorrhea

Compartment IV
Central Nervous System-Hypothalamus

- Psychogenic conditions (stressful situations, changes in the environment, anxiety, personality disorders, etc.)
- Mental retardation.
- Pseudocyesis.
- Anorexia nervosa.
- Obesity.
- Weight loss and malnutrition.
- Hypogonadotropic hypogonadism.
- Delayed puberty.
- Adiposogenital dystrophy, Frohlich's syndrome.
- Amenorrhea-galactorrhea syndromes (Chiari-Frommel, Ahumada-Del Castillo, heroin addiction and others related to pharmacologic conditions).
- Postpill amenorrhea.
- Generalized hypothalamic defect with deficiency of all the releasing factors or isolated gonadotropin deficiency.
- Systemic infections and chronic diseases including malignancy.
- Conditions associated with elevated prolactin levels.

- Conditions with elevated estrogen and androgen levels, or associated with an altered metabolism of these substances:
 - Cirrhosis of the liver.
 - Thyroid disorders.
 - Diabetes mellitus.
 - Adrenal diseases. Adrenogenital syndrome and related disorders, Cushing's disease and syndrome, Addison's disease.
 - Functioning ovarian tumors.
 - Ectopic gonadotropin production.
- Other causes.

Compartment III
Pituitary Gland

- Insufficiency of failure: Sheehan's syndrome, Simmonds' disease.
- Tumors of the pituitary gland, stalk, or suprasellar space.
- Pituitary selective deficiency of gonadotropin production.
- The empty sella syndrome.
- Status postsurgery or irradiation.
- Other causes.

Compartment II
The Ovary

- Hormone-producing ovarian tumors.
- Stein-Leventhal syndrome and polycystic ovarian disease.
- Ovarian hyperthecosis (Diffuse ovarian stromal luteinization).
- The resistant ovary syndrome.
- Premature ovarian failure: Idiopathic precocious menopause. Autoimmune disease. Mosaicism (presence of Y chromosome gonadal dysgenesis).
- Gonadal agenesis (Turner's syndrome).
- Congenital absence of the ovaries or oophorectomy.
- Severe inflammatory disease (oophoritis) with bilateral ovarian destruction.
- Persistent corpus luteum.
- Other causes.

Compartment I
The Uterus and the Genital Tract Outflow

- Congenital anomalies: Absent, hypoplastic or deformed uterus. Occlusion of hymen, vagina, or cervix. Infantile genitalia. Female pseudohermaphroditism. Congenital absence of the vagina.
- Testicular feminization syndrome.
- Asherman's syndrome (intrauterine adhesions): Tuberculosis. Suppurative endometritis. Radiation. Traumatic curettage.
- Hysterectomy or extensive partial removal of the uterus.
- Idiopathic unresponsive endometrium.
- Other causes.

HORMONES

The lining of the uterine cavity is stimulated and regulated by estrogen and progesterone. Originating in the ovaries, these hormones are secreted by the ovarian follicles. The function of the follicular apparatus is stimulated by the gonadotropins, follicle-stimulating-hormone (FSH) and lu-

"... it is vitally important to remember that patients with pituitary, hypothalamic, or suprasellar tumors often have hyperprolactinemia. . ."

"Of amenorrheic patients, 20 percent have elevated prolactin while prolactin-secreting adenomas are found in 65 to 79 percent of this hyperprolactinemic amenorrhea group.¹⁰"

teizing hormone (LH), which originate in the anterior pituitary gland. In turn, secretion of the gonadotropins is controlled by specific peptide-releasing hormones produced in the hypothalamus that act on the anterior pituitary gland. A complex mechanism regulates these releasing hormones and integrates the biophysical and biochemical information, comprised of feedback levels of ovarian hormones and pituitary gonadotropins and neurohumors derived from higher hypothalamic and other CNS centers. The releasing hormones respond to both internal and external environmental information.

PROLACTIN

Prolactin is secreted by acidophil cells situated in the lateral portions of the anterior pituitary.

The existence of prolactin in humans was not proved until 1971. This hormone, which is a polypeptide with a molecular weight of 20,000, is regarded as quite similar to human growth hormone (HGH) and human placental lactogen (HPL). In humans, the principle control of prolactin secretion is inhibitory. The hypothalamic inhibitory factor (termed prolactin inhibitory factor or PIF) has not been characterized, but is presumed to be dopamine or a related neurotransmitter. Prolactin is the only known pituitary hormone whose secretion is under tonic inhibitory control. Removal of this control factor obviously will lead to increased prolactin secretion. The mean, basal prolactin level of normal, nonpregnant, nonlactating women is 9 ± 0.5 ng. per ml; no consistent demonstration of fluctuation in prolactin levels during the menstrual cycle exists. Yet a linear rise in prolactin in normal pregnancy occurs. The prolactin values of non-nursing, postpartum women return to normal within one to two weeks, whereas lactating women demonstrate a pronounced prolactin response to suckling. Beyond eighty days postpartum, the prolactin levels are normal and indicate no response to suckling.

It appears obvious that prolactin plays a major role in mammary growth and development and in the establishment of lactation. The hormone has several actions in animals, including mammary development, lactation, sexual development, luteotrophic and luteolytic properties, and osmoregulation. In humans, in addition to breast and lactation stimulation, physiologic amounts of prolactin appear necessary for normal ovarian steroidogenesis. The exact mechanism of action of prolactin is uncertain.

Excess prolactin may cause amenorrhea or galactorrhea, defined as breast secretion of a milky fluid, unrelated to pregnancy or lactation. The quantity of secretion, which may come from one or both breasts, is not an important criterion. The mechanism of action is apparently direct stimulation of the mammary cells by prolactin. Abnormal levels of prolactin may cause amenorrhea in either of two ways:

1. By interfering with the secretion of gonadotropin-

releasing hormones, thereby preventing secretion of LH and FSH.

2. By blocking the action of LH and FSH at the gonadal level.

From the clinical point of view, it is vitally important to remember that patients with pituitary, hypothalamic, or suprasellar tumors often have hyperprolactinemia, which ordinarily is accompanied by amenorrhea and/or galactorrhea. The elevated levels of prolactin are attributed to several factors. The tumor itself may secrete prolactin, or the tumor by compression, may interfere with the hypothalamic-pituitary-portal system (which transports PIF to the pituitary). The decrease in PIF frees the cells from their inhibitory control, thus increasing the secretion of prolactin. Hypothalamic or suprasellar tumors also can interfere directly with the synthesis or release of PIF from the hypothalamus. An important general rule is to require all patients with primary and secondary amenorrhea, galactorrhea, and galactorrhea-amenorrhea syndromes to have determinations for prolactin levels and roentgenographic examination of the sella turcica made to rule out possible tumor.^{3,4} Hyperprolactinemia occurs in approximately 30 percent of patients with galactorrhea alone and 50 percent or more of those with amenorrhea and galactorrhea combined. Of amenorrheic patients, 20 percent have elevated prolactin while prolactin-secreting adenomas are found in 65 to 79 percent of this hyperprolactinemic amenorrhea group.¹⁰ There are several conditions characterized by elevated blood prolactin levels^{4,7,8} (table 2).

THE DIAGNOSTIC EVALUATION: (figure 2)

Normal menstrual function depends on the physiologic integrity of several systems. Speroff, Glass and Kase³ have outlined the modern diagnostic assessment of amenorrhea. It is practical to employ a diagnostic evaluation which separates the causes of amenorrhea into various compartments:

Compartment I	: Disorders of the outflow genital tract or uterus.
Compartment II	: Disorders of the ovary.
Compartment III	: Disorders of the anterior pituitary.
Compartment IV	: Disorders of the central nervous system (hypothalamus).

FIRST STEP: PROGESTERONE CHALLENGE AND PROLACTIN ASSAY

Thorough history, physical and pelvic examination are essential prior to the endocrine evaluation of a patient with amenorrhea. Occasionally, amenorrhea may be the only complaint, but following an adequate history and physical examination, specific diagnostic clues often are obtained. Strict adherence to the diagnostic steps is essential since premature diagnosis may lead to erroneous management.

"Thorough history, physical and pelvic examination are essential prior to the endocrine evaluation of a patient with amenorrhea."

"... if the serum prolactin level is elevated, polytomography of the sella turcica is mandatory."

The possibility of pregnancy always should be investigated prior to the first step.

In order to determine the level of function of the hypothalamic-pituitary-ovarian-uterine axis, a course of treatment with a pure progestational agent must be given orally or intramuscularly. A single dose of 100 to 200 mg. progesterone in oil administered intramuscularly or an orally active compound (eg., medroxyprogesterone acetate (Provera®), 10 mg. daily for five days is prescribed. Other progestins, including those in birth control pills, are inadequate because eventually they are metabolized to estrogens, consequently they do not produce a purely progestational effect. Within two to seven days after the conclusion of the progestational medication, the patient will experience a positive or negative withdrawal bleeding. If bleeding is observed by any amount more than spotting, the following conclusions are warranted:

1. The uterus has an endometrium capable of functioning and a patent outflow genital tract.
2. Estrogen activity is present, as the progesterone could act only on an endometrium adequately primed with estrogen.
3. The indirect presence of estrogen indicates ovarian function.
4. The pituitary gland is able to secrete FSH and LH.
5. There is at least minimal function of the hypothalamus with production of releasing hormones (gnRH).

From the clinical point of view, a positive withdrawal response to progesterone indicates that the hypothalamic-pituitary-ovarian-uterine axis is at least minimally intact and functioning, nevertheless perfect synchrony of these systems is not present resulting in anovulation.

Considering the serum prolactin level is normal (less than 20 ng/ml), further evaluation for the presence of a pituitary tumor is not required. In the presence of a positive bleeding response to progesterone, absence of galactorrhea and a normal prolactin level together rule out the presence of pituitary tumor eliminating further evaluation. On the contrary, if the serum prolactin level is elevated, polytomography of the sella turcica is mandatory. Prolactin levels above 260 ng/ml or higher in patients with amenorrhea is much more suggestive of a pituitary tumor than of any other disorder.¹⁰

SECOND STEP: ESTROGEN-PROGESTERONE CYCLE

If the progesterone challenge does not produce withdrawal flow, the causative factor either will be found in Compartment I (genital tract outflow, uterus, or endometrium) or failure of the preliminary estrogen preparation of the endometrium. A trial of cyclic estrogen and progesterone will clarify the problem. The rationale is predicated on the principle that estrogen given in adequate quantity and duration is certain to stimulate the endometrium and will

Table 2
Conditions Associated with Elevated Prolactin Physiologic Conditions

Pregnancy
Postpartum
Suckling and breast manipulation
Neonatal period
Exercise
Stress
Intercourse
Sleep

Pharmacologic Conditions

Stimulation tests: Synthetic thyrotropin-releasing hormone (TRH); Insulin tolerance test (hypoglycemia); Chlorpromazine test.
Estrogen (when administered in high doses).
Oral contraceptives.
Psychotropic drugs.
General anesthesia.

Pathologic Conditions

Galactorrhea-Amenorrhea syndromes (Postpartum or Chiari-Frommel; secondary to pituitary tumor or Forbes-Albright; idiopathic or Ahumada-Del Castillo syndrome).
Pituitary tumors secreting prolactin
Pituitary stalk section with disturbances of hypothalamic-pituitary relationship (stalk section, intra or suprasellar tumors, encephalitis, pseudotumor cerebri).
Hypothyroidism
Renal failure
Ectopic production by a malignant tumor (hypernephroma, bronchogenic carcinoma).
Surgical stress
Neurogenic (stimulation of breast or chest wall such as thoracic surgery, breast surgery, burns, herpes zoster, dermatitis and lesions of afferent pathway such as syringomyelia and tabes dorsalis).
Other causes.

produce withdrawal bleeding, provided a reactive endometrium and patent genital outflow exist. The appropriate oral dose is 2.5 mg. conjugated estrogen (Premarin®) daily for 21 days. Secondly, the addition of a progestational agent (Provera®) 10 mg. daily orally for the last five days will enhance withdrawal bleeding. In the absence of a withdrawal flow, the diagnosis of a problem in Compartment I is made. If menses occurs after the course of cyclic estrogen-progesterone, it is apparent that the uterus, endometrium, and genital flow tract are intact (Compartment I) and able to function if properly stimulated by estrogen.

Progesterone-induced withdrawal bleeding had been used frequently in the past as a test of pregnancy; after progesterone challenge, the absence of withdrawal bleeding was considered evidence of pregnancy. Presently progesterone-induced withdrawal bleeding cannot be recommended as a

Figure 2*



*Modified from Speroff L, Glass RH, Kase NG: *Clinical Gynecologic Endocrinology and Infertility*, 2nd ed. Baltimore, Williams and Wilkins, 1978, pp. 100.

test for pregnancy solely because of the high incidence of false-positive and false-negative results. Possible medicolegal implications also may develop due to the potential teratogenic effects upon the fetus. A new generation of pregnancy tests (radioimmunoassay and radioreceptor assays for the detection of human chorionic gonadotropin), able to detect pregnancy even before the first missed period, makes this approach obsolete.⁹

THIRD STEP: GONADOTROPINS ASSAY (FSH, LH)

If Compartment I is found intact, the cause for inadequate levels of endogenous estrogen necessary to stimulate the endometrium may hinge on the failure of the ovary (Compartment II) to produce estrogen, failure of the anterior pituitary (Compartment III) to produce FSH and LH for normal ovarian stimulation, or failure of the hypothalamus (Compartment IV) to produce gonadotropin-releasing factors that will stimulate the anterior pituitary secretion of FSH and LH, resulting ultimately in ovarian stimulation and production of estrogen. Step three effectively will rule out ovarian failure (Compartment II). A minimum two-week delay following the estrogen-progesterone administration (step 2) is necessary before proceeding with the gonadotropin assay; because the levels of endogenous gonadotropins (FSH, LH) may be temporarily reduced.

At present, the most reliable test for the determination of FSH and LH is the radioimmunoassay. The radioimmunoassay of gonadotropins in serum is not an esoteric test and the results from a single blood specimen are normally processed within two weeks from any commercial laboratory at a reasonable cost. Normal ranges for serum FSH and LH are 5-30 mIU/ml and 5-20 mIU/ml respectively. For both hormones, values below 5 mIU/ml are considered abnormally low, while abnormally high readings

register above 40 mIU/ml for FSH and above 30 mIU/ml for LH. Furthermore, it is important to remember that there is a midcycle surge of gonadotropins in which case LH would be approximately three times the baseline value. Therefore, if only one patient sample is utilized and is found to be elevated, coupled with the absence of bleeding two weeks following the sampling (midcycle surge), the high levels safely can be interpreted as abnormal, avoiding expensive serial determinations.

The result of the gonadotropin assay will be abnormally high, abnormally low, or in the normal range. An elevated FSH level (above 40 mIU/ml) and LH level (above 30 mIU/ml) together reliably will indicate ovarian failure. A high FSH has proved the more dependable indicator of ovarian failure than a high LH. High levels of LH alone do not establish a reliable diagnosis. A repeat sampling usually is recommended before a definite diagnosis commitment.

All patients with elevated gonadotropins must have a karyotype study in order to rule out the presence of a Y chromosome. In addition, a blood assay for the H-Y antigen (Y-induced histocompatibility antigen) which detects the presence of a testicular tissue, even in the presence of a normal karyotype (46XX), is advisable. The presence of a Y chromosome in a female is associated with a 25 percent incidence of malignant transformation within the gonad. Consequently, when a Y chromosome is detected or a positive H-Y antigen is present, gonadectomy should be performed. The cautious physician will note that even the normal-appearing adult female with elevated gonadotropins may have a silent Y chromosome. This frequently is found in cases of mosaicism (multiple cell lines of different sex chromosomes) where premature menopause with ovarian failure and elevated gonadotropins may be the only clinical stigmata.

If the gonadotropin level is abnormally low or in the normal range, one final test is required to distinguish between a pituitary (Compartment III) or CNS-hypothalamic factor (Compartment IV). Polytomography of the sella turcica is required to rule out a pituitary tumor. The polytomography is able to detect tumors of five to ten mm in size, and is the preferred test over the inadequate routinely used x-ray skull film. Small tumors cannot be detected by a simple skull film. As has been noted, polytomography also is indicated if the patient has galactorrhea or elevated prolactin levels. Because of the possibility of hypothyroidism as a causative factor, a thyroid profile including TSH is important in the presence of galactorrhea and/or elevated prolactin.⁸ When an abnormal sella turcica is found by tomography, visual field examination is valuable. Unfortunately, it is usually normal unless significant changes in the sella turcica already exist. Presently the serum prolactin levels and the polytomography of the sella turcica are the choice screening procedures for pituitary tumor while computerized axial tomography, pneumoencephalography, and angiography are useful ancillary diagnostic aids. From a practical clinical point of view, it should be emphasized that patients complaining of amenorrhea as the only presenting symptom in an otherwise normal individual, should have sella turcica evaluation and prolactin levels annually as a precaution to rule out a slow-growing pituitary tumor. Such neoplasms may be present with amenorrhea years prior to radiologic evidence of abnormality.

If the polytomography is normal, a failure of the CNS-hypothalamus (Compartment IV) is the most likely diagnosis. This diagnosis should be made by exclusion of pituitary pathology since the exact mechanism of hypothalamic suppression is not clear at the present time.

It is not known why paradoxical findings of normal FSH and LH values occur in some patients with hypogonadotropic conditions where low values would be expected. The significant practical and clinical point is that gonadotropin levels in the normal range, in the presence of a negative challenge with progesterone, are consistent with Compartment III or IV failure.

SUMMARY

Amenorrhea is the complete absence of menstruation during the reproductive span of life. This clinical symptom, rather than a precise diagnosis, may result from many possible causes, some of which have no serious medical

consequence. Others bear serious, morbid and possibly lethal consequences and although it may not be necessary to treat every amenorrheic patient, a specific diagnosis must be attempted in each case.

Most patients with this condition can be diagnosed readily and managed by the primary care physician if a rational strategy is followed in the investigation. On the contrary, however, busy practitioners frequently dismiss such patients as too complex for care resulting in automatic referrals to "specialists." Other physicians seem compelled to initiate cyclic uterine bleeding without adequate investigations to determine the possible presence of serious etiologic factors. Both courses of action may be unnecessary, costly and inconvenient to the patient. A considerable wealth of knowledge has been accumulated in the last decade affording simple, expedient procedures to the physician for the clinical evaluation of patients with amenorrhea.

Strict adherence to the evaluation elaborated upon reliably will localize the cause. If necessary, but only if so, should consultation or referral to the appropriate specialist (gynecologist, endocrinologist, internist, neurosurgeon, psychiatrist) be made. Confident knowledge that the referral is appropriately indicated will keep expenses and tests to a minimum.

REFERENCES

1. Kistner RW: *Gynecology: Principles and Practice*, 3rd ed. Chicago, Year Book Medical Publishers, 1979, pp 595-661.
2. Gold JJ: *Gynecologic Endocrinology*, 2nd ed. New York, Harper and Row, 1975, pp 191-212.
3. Speroff L, Glass RH, Kase NG: *Clinical Gynecologic Endocrinology and Infertility*, 2nd ed. Baltimore, Williams and Wilkins, 1978, pp 93-121.
4. Quigley MM: Prolactin in human reproduction. *J Cont Ed Obstet Gynecol* 20:31, 1978.
5. Green TH: *Gynecology: Essentials of Clinical Practice*, 3rd ed. Boston, Little, Brown, 1977.
6. Kessler AK, Reyeroft D: *Adolescent Obstetrics and Gynecology*. Chicago, Year Book Medical Publishers, 1978, pp. 25-45.
7. Pelosi MA, Sama J, Caterini H, et al: Galactorrhea-amenorrhea syndrome associated with heroin addiction. *Am J Obstet Gynecol* 118:966, 1974.
8. Pelosi MA, Langer A, et al: Galactorrhea associated with primary hypothyroidism. Report of two cases. *Obstet Gynecol* 49: (Supplement) 125, 1977.
9. Pelosi MA, Apuzzio J, Harrigan JT: Pregnancy tests. The new generation. *Contemp Obstet Gynec* (In Press).
10. Turksay RN: Evaluating hyperprolactinemia: Which tests to use. *Contemp Obstet Gynecol* 15:91, 1980.

MEDICAL HISTORY

“Punch Cures the Gout”

RICHARD P. WEDEEN, M.D., East Orange*

In eighteenth century England medical progress failed expectations. The Renaissance in science promulgated by Francis Bacon, William Harvey, Issac Newton and Robert Boyle was met in clinical practice more by pretension than accomplishment. The resulting ambivalence toward medicine found popular expression in satire. “Punch cures the gout,” was the title of one of the more famous caricatures drawn by James Gillray in 1799 (Figure 1). Based on a popular doggerel of the period, the theme reveals a basic confusion about causality that never has been entirely erased. “Punch cures the gout, the colic and the ‘tisis,’” recite the figures. “And is by all agreed,” the verse continues, “the very best of physick.”

Punch was a popular fruit drink heavily laced with West Indian rum. From time immemorial gout was considered a consequence of intemperance. But rum punch was not only associated with acute arthritis of the great toe, “regular gout,” but also with the colic and the phthisic, symptoms referred to at the time as “irregular” gout. Modern physicians have replaced the term “irregular” with “non-articular,” and have discarded most of the afflictions formerly included under this heading. “Colic” today would be considered indicative of lead poisoning, while “tisis” is consistent with any form of cachexia including that of chronic lead intoxication. Among the serious disorders included in “irregular” gout, only kidney disease has withstood the test of twentieth century scrutiny. Until very recently

renal failure was considered the major cause of premature death among gout patients. A review of the recurrent controversies surrounding gout suggests that sporadic and often undetected lead poisoning played a key role in the renal manifestation of this disease in the present as well as the past.

CADWALADER OF TRENTON

In retrospect, the history of lead poisoning can be traced to ancient Greece and Rome. It has been hypothesized that lead in Roman wines may have contributed to the downfall of that ancient empire.¹ Modern understanding of this disease has, however, important roots much closer to home: Trenton, New Jersey. In 1745, Benjamin Franklin published a pamphlet by Thomas Cadwalader entitled, “An Essay on the West India Dry Gripes.”² Cadwalader was one of the most distinguished physicians in the American colonies. Trained at Rheims and later under William Cheselden, the eminent English anatomist, Cadwalader practiced in Philadelphia and was among the first physicians appointed to the staff of the Pennsylvania Hospital at its foundation in 1752.³ After marrying Hannah Lambert, the daughter of a prominent citizen of Trenton, Cadwalader gave up a large medical

*Read before the first meeting of the Medical History Society of New Jersey, October 8, 1980, Rutgers Medical School, Piscataway. Dr. Wedeen is Associate Chief of Staff for Research and Development, VA Medical Center, East Orange, NJ and Professor of Medicine, CMDNJ, New Jersey Medical School Newark, NJ. He may be addressed at the VA Center in East Orange.



Figure 1—"Punch cures the gout." This caricature was drawn by James Gillray who suffered from the gout.

practice in Philadelphia to move to New Jersey. He became a leading political figure in Trenton, serving as first Burgess in 1746, in addition to holding many important governmental and educational offices in both Pennsylvania and New Jersey. His son, John Cadwalader, was to become one of the foremost Generals of the Revolutionary War.

Cadwalader's "Essay" on the dry-gripes turned out to be one of the most influential medical contributions to emerge from the American colonies. This New Jersey physician appears to have been the first to recognize that the prevailing view of the cause of the colic was untenable. Cadwalader specifically rejected the opinion promulgated by Citois in 1616, that the colic of Poitou was due to the acid residues of citrus fruits. In the West Indies, Cadwalader noted, fruit juices were used to cure the dry-gripes and therefore could not be its cause. "It has likewise been observed," he reported "that since the People of America have drank Punch with more Water . . . yet with much more Lime juice than formerly, the Dry-Gripes is not near so common as before this Custom prevailed."

Cadwalader discerned the similarity between the dry-gripes and lead colic (*colica pictonum*). "I have seen in England," he continues, "two instances of the Success attending the Methods here laid down for the Dry-Gripes in the Cholica Pictonum, arising from the Fumes of White-lead, which gives Reason to hope, that by a further trial of it in Europe, it would be found as beneficial in the latter Distemper, as it is in the former." This passage indicates clearly that Cadwalader saw the dry-gripes arising from rum punch as similar to that arising from the fumes of white lead. The originality of this observation has sometimes been overlooked, perhaps because of the discursive style of the "Essay."⁵

Cadwalader's contribution was, however, theoretical rather than conclusive. He did not make the necessary measurements to prove the lead hypothesis. But in accordance with his stated intent, Cadwalader influenced Europeans to undertake the necessary experiments. In 1785 one John Hunter (not the British surgeon), confirmed Cadwalader's hypothesis by measuring the lead content of Jamaican rum.^{5,6}

APPLICATION OF CHEMISTRY

The critical application of the new science of chemistry to the detection of lead in biological fluids had been performed

on Devonshire cider by George Baker in 1767, twenty-two years after Cadwalader's "Essay." Cadwalader's ideas had been transmitted to George Baker by Benjamin Franklin. Presenting the results of his studies of the cause of the Devonshire colic to the Royal Academy of Physicians in London, George Baker acknowledged the contribution of his American friends. While not mentioning Cadwalader by name, Baker's account closely follows that of the New Jersey Physician:⁷

"Dr. Franklin likewise informed me, that the colic of Poitou is not so frequent a disease in any of the colonies, as it was formerly; and the reason, commonly assigned, is, that the people now drink their punch very weak in comparison with what they were formerly accustomed to; which used to be rum and water in equal quantities. He added, that they now also drink their punch with more juice of fresh limes in it; and, as that juice joined to certain laxative medicines, is at present their common remedy, when any are seized with the disease, showed that it was generally the best preservative against it."

In a letter to Cadwalader Evans written in 1767, Franklin, too, recalled these conversations with George Baker:⁸

"I had before acquainted Mr. Baker with a Fact of this kind, the general mischief done by use of Leaden Worms, when Rum distilling was first practiced in New England, which occasioned a severe law against them; and he has mentioned it in the second part of his piece not yet published."

Franklin was referring here to a law enacted in the Massachusetts Bay Colony in 1723 "for preventing abuses in distilling of rum and other strong liquors, with leaden heads or pipes."

George Baker proved Cadwalader's speculation beyond doubt. His landmark contribution was, however, greeted with as much controversy as acclaim throughout the world. The conclusion that lead in cider was the cause of the epidemic colic and palsy of Devonshire (Figures 2 and 3), of course, eventually prevailed. Baker's omission of gout and lead nephropathy as delayed consequences of chronic lead ingestion, however, became a source of confusion which has persisted to the present.

The first statement that lead contributed to the development of gout was recorded by one of Baker's staunchest supporters, James Hardy.⁸ Embroiled in the polemics surrounding the cider of Devon, Hardy's observations on the association of gout with lead were obscured by his rhetoric. In 1778 he prepared a broad defense of Baker's thesis entitled "A candid examination of what has been advanced as the Colic of Poitou and Devonshire, with remarks on the most probable cause and experiments to ascertain the true cause of gout." Two years later, mounting another vigorous rebuttal of Baker's local critics, Hardy included his conclusion concerning gout in his title⁹ (Figure 4):

"Gout originates from the action of mineral substances, especially those conveyed into the human system by the medium of adulterated wines."

By "mineral substances" Hardy meant primarily lead, but did not exclude the possibility that gypsum, mercury, antimony, zinc or arsenic might also contribute to gout.

In contrast to Baker, Hardy gave credence to the earlier writings of Citois, Musgrave, and Huxham describing gout as a late sequela of lead colic. But Hardy was only a minor figure in the interminable debates on both lead and gout, and



Figure 2—"The Cholic." This caricature drawn by George Cruickshank in 1806 depicts the exquisite abdominal pain unassociated with diarrhea now recognized as due to lead. In 1833 Daumier drew a French version of this theme; "La Colique."

no one seems to have paid much attention to his views. Once again the practice of medicine showed little immediate benefit from scientific progress. Poison was still to be found in the pot (Figure 5), and a good belly-ache still followed cheap cider (Figure 6); death served the poisoned punch (Figure 7). The Renaissance in medical practice had to await the systematic application of scientific techniques to biological problems in the nineteenth century.

It was Alfred Barring Garrod who showed the way to end the ambiguity and speculation about gout with his "uric acid string experiment" of 1848.¹⁰ Despite the crudeness of this blood test, physicians subsequently could begin to separate urate-induced arthritis from the vast array of "irregular" manifestations previously ascribed to gout. In his comprehensive book on gout published in 1859,¹¹ Garrod emphasized the importance of renal disease in the uric acid diathesis.

GOUT NEPHROPATHY

Gout nephropathy was first mentioned by F.P.O. Rayer in his massive atlas of renal pathology published from 1837 to 1842.¹² Strongly influenced by the seminal contributions of Richard Bright, Rayer classified "Néphrite Goutteuse" among the proteinuric renal diseases. Garrod did not contest this classification, although he recognized that proteinuria was unusual until very late in the course of the disease—after more than twenty years of gout.¹³

Although de Haen and Forbes,¹⁴ as well as Rayer, previously had noted tiny concretions within gouty kidneys (presumably representing intrarenal uric acid microcalculi), Castelnau is generally credited with the earliest description of the specific intraluminal uric acid deposits, in 1843. Such deposits now are recognized as a consequence of severe hyperuricemia with or without gout.^{15,16} In 1862, Jean Charcot published illustrations of the characteristic white striations in the renal medulla and indicated further that uric acid microtophi sometimes also were to be found in the renal cortex of the gouty kidney¹⁷ (Figure 8).

The writings of Garrod and Charcot were widely disseminated. They established renal disease due to stones or intrarenal urate deposition as common knowledge among physicians throughout the world. However, the pathogenesis of kidney disease without specific urate or uric acid deposits

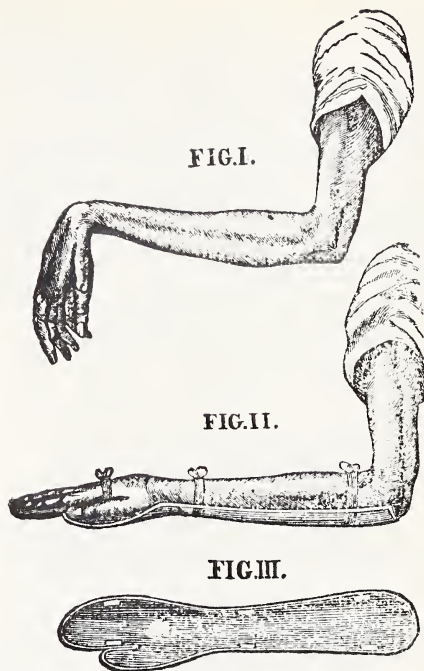


Figure 3—An illustration of a splint designed by C.R. Pemberton for the treatment of lead palsy. From "A practical treatise on Various Diseases of The Abdominal Viscera." Worcester: GA Trubuli; 1815.

remained unclear and the subject of continuing debate. In twentieth century America the histologic diagnosis "pyelonephritis" was commonly made in gouty kidneys and mistakenly interpreted as implying an infectious etiology.¹⁸ Pathologists today would be less presumptuous; such histologic findings would be more cautiously termed "interstitial nephritis."¹⁹

The belief that renal disease is the major cause of death in patients with gout was challenged by reports appearing in the 1970's. Long-term followup studies performed at the Mt. Sinai Medical School in New York indicated that gout, by itself, rarely results in renal failure unless other kidney disease supervenes.²⁰ These contradictory findings were supported by reports emanating from California that hyperuricemia, too, does not lead to renal failure even after decades of followup.²¹

A possible resolution of the conflicting views of gout nephropathy was to be found in Garrod's classic description.¹¹ Garrod was aware that at least one-quarter of his patients were lead workers. Most had experienced symptomatic lead poisoning at one time or another. But lead poisoning may have been far more prevalent in London of the eighteenth and nineteenth centuries than even Garrod suspected.

Port and madeira had been the favorite beverages of the British ever since the treaty of Methuen of 1703 which lowered the import duties on Portuguese wines relative to French wines.²² In 1897, G.H. Ellwanger, a journalist and long sufferer from the gout, reported that Iberian wines were

AN
ANSWER
TO THE
LETTER

ADDRESSED BY
FRANCIS RIOLLAY, ✓
PHYSICIAN OF NEWBURY,

TO
Dr. HARDY, on the Hints given concerning
the Origin of the GOUT, in his Publication
on the COLIC OF DEVON, 2271

IN WHICH
The several Objections made by Dr. HARDY are
considered; and the Probability that the GOUT
originates from the Action of Mineral Substances,
especially those conveyed into the Human System by the
Medium of adulterated Wines, is more fully infilled on,

By JAMES HARDY, M.D. ✓

LONDON:
Printed for T. CADELL, in the Strand; and
RICHARDSON and URQUHART, at the Royal
Exchange. MDCCLXXX.



Figure 4—Title page of James Hardy's pamphlet describing saturnine gout.

adulterated for export to prevent spoilage during shipment.²² He considered lead one of many deleterious contaminants in the imported brews which were responsible for the prevalence of gout in England. In 1971, Gene Ball, fresh from studies of saturnine gout and nephropathy among moonshine whiskey consumers in the southeastern United States,^{23,24} tested some preserved samples of nineteenth century Iberian wines for lead and found that the Englishmen's favorite drink was indeed loaded with the heavy metal. The finding of lead in port and madeira raised the question as to whether lead has, from time to time, been the cause of renal disease in gout. As is so often the case, the question was by no means new.

The first description of lead nephropathy appeared in 1862 by Lancereaux²⁵. This French physician recognized that renal disease from lead was characteristically an interstitial nephritis which differed from the usual Bright's disease by the absence of proteinuria. Lancereaux noted further, that renal disease in gout was often indistinguishable from that of chronic lead poisoning. "The nephritis and arthritis of saturnism," he wrote in 1881, "are precisely the identical lesions of nephritis and arthritis of gout".²⁶ The prevalence of gout in lead nephropathy contrasts with its virtual absence in other forms of renal disease.

Neither Lancereaux's contemporaries nor his successors seemed to have paid much attention to his conclusions. Yet

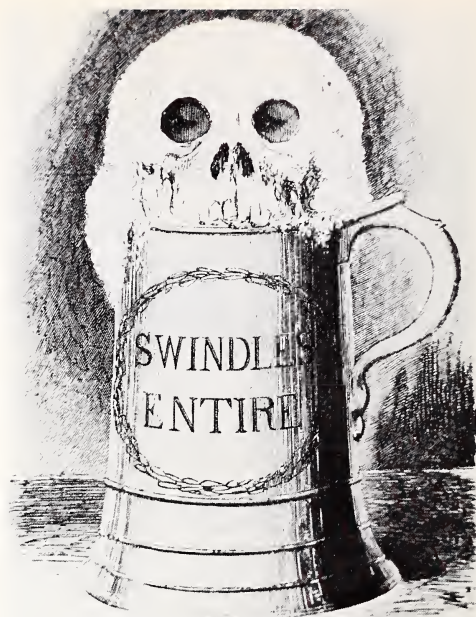


Figure 5—"Poison in the Pot." Illustration from a temperance broadside by George Cruickshank. Lead is cited in the attached text as one of the adulterants.

lead could not only explain the variable occurrence of renal disease in gout, but also the long and conflicting history of "irregular" gout. The association of gout with colic and palsy in earlier times might, indeed, more often have been due to chronic lead intoxication than the transient metabolic changes which more recently have been documented from alcohol.²⁷ Lead nephropathy in gout patients also could explain the failure of allopurinol therapy to alter the course of the gouty kidney.²⁸

We recently have tested Lancereaux's hypothesis in gout patients at the Veterans Administration Medical Center in East Orange.²⁹ To detect excessive lead exposure we relied neither on the patient's history nor the blood lead concentration. Instead we used the EDTA lead-mobilization test which had proved more reliable than any other method for the detection of occupational lead nephropathy among asymptomatic leadworkers in New Jersey.³⁰ EDTA is a chelating agent which binds lead stored in the body, particularly in the bones, and permits it to be excreted in the urine. Normal subjects and patients with renal failure who have had no unusual lead exposure excrete less than 600 ug of lead within three days during the provocative test.³¹ In contrast to the gout patients followed in New York and California, renal failure is very common among veterans in East Orange. Twenty-two of our forty-four patients had renal failure as defined by a serum creatinine greater than 1.5 mg/dl. Sixty percent of the gout patients with renal failure had excessive mobilizable lead as compared to only 18 percent of the gout patients with normal serum creatinines. The degree of renal failure in these men correlated directly with the amount of mobilizable lead. These findings seem to support the older



Figure 6—"The Blessings of Cheap Cider" was drawn by W. Heath in 1850 indicating that George Baker's exposition of the cause of Devonshire colic was not entirely successful in eliminating the disease from England.

view that lead not only predisposes one to gout, but that saturnine gout is particularly likely to end in renal failure. They confirm the observations of Charcot who wrote in 1878:¹⁷

"The gout of saturnine subjects from what I have seen, appears to differ from ordinary gout only in the greater rapidity of its evolution, the abundance of tophaceous deposits and the necessary existence, so to term it, of renal lesions."

If the history of medicine teaches us anything it is that association does not prove causation. Such ancient controversies as saturnine gout and nephropathy cannot be resolved with so simple a correlation as we have found.

The hypothesis is, however, attractive from the historical point of view: perhaps the concept of "irregular" gout was closer to the mark than contemporary experience would suggest; the colic and the phthisic might well be closely associated with saturnine gout. Wine as a cause of gout might have been a more compelling clinical explanation than seems plausible from contemporary textbooks. But the impact of our findings on the future may be even more important than their contribution to understanding of the past. Prevention and cure of gout nephropathy may be feasible.

FINALE

The history reviewed here of lead, wine, gout and the kidney is aptly summarized in the title page from a book on



Figure 7—"The End of Life." Death served this punch. The central figure has both feet wrapped in flannel indicative of the gout. From "The English Dance of Death" illustrated by R. Rowlandson 1815.



Figure 8—Illustrations of the gouty kidney published by Jean Charcot in 1862. The white striations in the outer medulla are the intraluminal urate deposits now recognized as a consequence of severe acute hyperuricemia usually arising from neoplastic or hemotologic disorders.

podagra of 1623. Panels at the top and along the sides illustrate the life of indulgence and debauchery: the pleasures of the hunt are accompanied by wine, women and song. The consequences are illustrated in the lower panels; a gouty old man hobbles on crutches surrounded by Venus and Bacchus. In the final panel our debauchee is bedridden, a terminal case, accompanied only by his uroscopist (an early nephrologist?) reading the invalid's sad fate in his urine (Figure 9).



Figure 9—Title page of the appendix to an antipodagra tract by M. Pansa published in 1623 illustrating the wages of sin (with uroscopist in attendance).

REFERENCES

- Gilfillan SC: Lead poisoning and the fall of Rome. *J Occup Med* 7:53-60, 1965.
- Cadwalader T: *An Essay on the West-India Dry-Gripes; with the Method of Preventing and Curing that Cruel Distemper. To which is added, an Extraordinary Case in Physick.* Philadelphia, Franklin, 1745.
- Editorial. Thomas Cadwalader (1708-1779). *JAMA* 207:553-554, 1969.
- Felton JS: Man, medicine and work in America: An historical series. IV. Thomas Cadwalader MD. Physician, Philadelphian and Philanthropist. *J Occup Med* 11:374-380, 1969.
- McCord CP: Lead and lead poisoning in early America. Benjamin Franklin and lead poisoning. *Ind Med Surg J* 22:393-399, 1953.
- Hunter J: Some experiments made upon rum, in order to ascertain the cause of the colic, frequent among the soldiers in the Island of Jamaica, in the years 1781 and 1782. *Med Tr Lond* 3:227-249, 1785.
- Baker G: Additional observations concerning the colic of Poitou. *Med Tr Lond* 3:407-447, 1785.
- Hardy J: *A Candid Examination of what has been Advanced as the Colic of Poitou and Devonshire, with Remarks on the Most Probable Causes and Experiments Intended to Ascertain the True Cause of Gout.* Devonshire, J Hardy, 1778.
- Hardy J: *An Answer to the Letter Addressed by Francis Riollou, Physician of Newbury to Dr. Hardy, on the Hints Given Concerning the Origin of the Gout, in his Publication on the Colic of Devon.* London, T Cadell, 1780.
- Garrod AB: Observations on certain pathological conditions of the blood and urine in gout, rheumatism and Bright's disease. *Med Chir Tr Lond* 31:83-97, 1847-1848.
- Garrod AB: *The Nature and Treatment of Gout and Rheumatic Gout.* London, Walton and Maberly, 1859.
- Rayer FPO: *Traite des Maladies des Reins.* Paris, JB Baillière, 1841.
- Garrod AB: Eczema and albuminuria in relation to gout. *Tr Int Med Congress* 7:99-202, 1881.
- Forbes M: *A Treatise Upon Gravel and Upon Gout.* London, T Cadell, 1787.
- Castelnau NF: Observations et réflexions sur la goutte et le rhumatisme, et spécialement sur quelques accidents graves qui peuvent se manifester dans le cours de ces deux affections. *Arch gen de Med Par* 3:285-314, 1843.
- Boss GR, Seegmiller JE: Hyperuricemia and gout. Classification, complications, and management. *N Engl J Med* 300:1459-1468, 1979.
- Charcot JM: *Lectures on Bright's Disease of the Kidneys.* Translated by Henry B Millard. New York, William Wood & Co, 1878.
- Talbott JH, Terplan KL: The kidney in gout. *Medicine* 39:405-467, 1960.
- Heptinstall RH: Interstitial Nephritis. A brief review. *Am J Pathol* 83:214-236, 1976.
- Berger L, Yu TF: Renal function in gout. IV. An analysis of 524 gouty subjects including long-term followup studies. *Am J Med* 59:605-613, 1975.
- Fessel WJ: Renal outcomes of gout and hyperuricemic. *Am J Med* 67:74-82, 1979.
- Eliwanger GH: *Meditations on Gout with a Consideration of its Cure Through the Use of Wine.* Cambridge, University Press—John Wilson and Son, 1897.
- Morgan JM: Chelation therapy in lead nephropathy. *South Med J* 68:1001-1006, 1975.
- Ball GV, Morgan JM: Chronic lead ingestion and gout. *South Med J* 61:21-24, 1968.
- Lancereaux E: Note relative a un cas de paralysie saturnine avec altération des cordons nerveux et des muscles paralysés. *Gaz med de Paris* 17:709-713, 1862.
- Lancereaux E: Néphrite et arthrite saturnines; coincidence de ces affections: parallèle avec la néphrite et l'arthrite gouteuses. *Arch gen de med Par* 6:641-653, 1881.
- Lieber CS, Jones DP, Losowsky MS, Davidson CS: Interrelation of uric acid and ethanol metabolism in man. *J Clin Invest* 41:1863-1870, 1962.
- Briney, WG: The influence of allopurinol on renal function, in gout. *Arth Rheum* 18:877 (Nov/Dec supplement), 1975.
- Tepper, EF, Lebeenthal M, Haddad B, Sampson L, Wedeen RP: Does lead cause gout nephropathy? *Clin Res* 27:500A, 1979.
- Wedeen RP, Mallik DK, Batuman V: Detection and treatment of occupational lead nephropathy. *Arch Intern Med* 139:53-57, 1979.
- Emmerson BT: Chronic lead nephropathy: The diagnostic use of calcium EDTA and the association with gout. *Aust Ann Med* 12:310-324, 1963.

Physician Due Process in Applying for Hospital Privileges

JAMES E. GEORGE, M.D., J.D. and
MADELYN SCHWARTZ QUATTRONE, Woodbury*

Hospital medical staff membership is essential to most physicians. Yet in some circumstances hospitals have a legal right to refuse medical staff privileges to professionally qualified physicians. This article explores the parameters of the hospital's discussion in matters of staff applications, and the legal rights of physicians whose applications have been denied.

Hospital affiliation is a professional and economic necessity for most physicians. Without hospital staff privileges many specialists would be effectively precluded from practicing their profession and primary care physicians would be unable to provide in-hospital care to their admitted patients.

Hospital "privileges" are so named because physicians, even though licensed and competent to practice medicine, have no absolute right to practice medicine in a particular hospital. The hospital and medical staff retain a large measure of discretion as to who may be granted privileges.

In the past decade, hospitals and the Joint Commission on Accreditation of Hospitals (JCAH) have created increasingly stringent requirements for medical staff membership. This trend can be traced to the increase in medical malpractice litigation, and even more particularly to the landmark judicial decision in the case of *Darling v. Charleston Memorial Hospital*, 211 N.E. 2d 253 (1965), cert. denied 383 U.S. 946 (1966).

Hospital officials have been vested with a large measure of discretion in regard to the selection of medical staff members. The medical staff also actively participates in, and sometimes controls, the privileges process. Abuse of these powers is not judicially condoned.

The Darling case helped to establish the doctrine of corporate negligence and ruled that a hospital may be held liable for injuries to patients resulting from medical malprac-

tice on the part of a medical staff physician where the hospital was negligent in failing to review a physician's work or to require appropriate consultation when necessary. The Darling case subsequently has been interpreted to include also a hospital duty to use reasonable care in the granting of staff privileges and a duty to limit or terminate medical staff privileges once the incompetence of a physician has become known.

As a result, hospitals have become more selective in appointing and reappointing physicians to their medical staffs. Controversy almost always arises when a hospital denies staff privileges to a qualified licensed physician. A number of such controversies have resulted in the filing of lawsuits by the physicians whose applications for staff privileges were denied.

This article briefly will discuss the parameters of a hospital's discretion in denying staff privileges. Attention will be focused on the judicially mandated "due process" rights which private hospitals in New Jersey increasingly must accord a physician before his application for staff privileges can be denied.

*Dr. George is a board certified emergency physician and attorney who is the Director of the Department of Professional Liability Control for the Medical Society of New Jersey. Madelyn Schwartz Quattrone is a law clerk for Dr. George and the Department of Professional Liability Control of the Medical Society of New Jersey. She will obtain her law degree from the Rutgers School of Law, Camden, NJ, in May, 1981.

"DUE PROCESS" CONSIDERATIONS

What is "due process of law"? Due process of law is a constitutional guarantee embodied in the Fifth and Fourteenth Amendments of the U.S. Constitution. Although the phrase has no fixed meaning, at a minimum, due process requires that an applicant or participant be given notice and an opportunity to be heard before his right or interest can be interfered with or taken away. This guarantee of due process is applicable only to the actions of the federal or state governments, not to private institutions.

Institutions otherwise deemed private may, however, fall under the requirements of the guarantees of the due process clause if the government has become so involved in their operations that the action of the "private" institution becomes "state action."

Thus, if it can be shown that the actions of a private hospital are essentially "state" action, the physician who applies for staff privileges may be entitled to constitutional due process of law before his application can be denied by the hospital.

How is it possible for a private hospital to become subject to the due process clause of the federal constitution? One theoretical example is the private hospital which receives federal funds through Medicare and Medicaid reimbursements or under the Hill-Burton Act. Furthermore, the private hospital may enjoy tax-exempt status and may be subject to state certificate-of-need review as well as cost-review legislation and the actions of federal and state health planning agencies.

If a court finds some or all of these factors so substantial as to render the actions of the otherwise "private" hospital "state action," the hospital may come under the umbrella protection of the due process and equal protection clauses of the Fourteenth Amendment of the U.S. Constitution.

However, the majority of federal courts have been unwilling to apply the "state action" concept to the private hospital due to its receipt of federal funds or its required compliance with state and federal regulations. Most federal courts continue to distinguish between the private and the public hospital. Thus, an aggrieved physician is generally without a federal remedy in staff application cases.

However, a few state courts have been willing to find the receipt of Hill-Burton funds to be enough state involvement to subject the private hospital to the due process and equal protection clauses of the U.S. Constitution. The closest a New Jersey court has come to applying the "state action" concept to a private hospital is the case of *Walsky v. Pascack Valley Hospital*, 145 N.J. Super. 393 (1976). In that case the hospital acknowledged receipt of Hill-Burton funds in its construction and expansion program. The New Jersey Superior Court, Chancery Division, noted that where a hospital has received funds or otherwise benefited from the Hill-Burton Act, federal constitutional mandates must be observed. Thus, the court struck down as violative of the Equal Protection Clause the hospital's moratorium prohibiting newly admitted members of the staff from seeking staff privileges elsewhere. This restriction did not apply to previously admitted members of the medical staff. The *Walsky* case will be treated in more detail when we consider the problem of the closed medical staff.

In addition to the "state action" theory, the judiciary in a few states, most notably New Jersey and California, is finding other means with which to protect the interests of physicians applying for staff privileges. The former landmark

New Jersey case was *Greisman v. Newcomb Hospital*, 40 N.J. 389, 192 A.2d 817 (1963).

There is little question in New Jersey that a private hospital which serves the general public must accord a physician a right to a fair hearing before it can reject his application for medical staff privileges.

GREISMAN CASE

The Greisman case involved a suit brought by an osteopathic physician against a private hospital which refused to consider his application for staff privileges. The plaintiff osteopathic physician contended that the hospital refused to consider his application solely because he was an osteopathic physician and did not satisfy a hospital bylaws requirement that applicants be graduates of AMA-approved medical schools.

In considering the Greisman case, the New Jersey Supreme Court swept away the traditional dichotomy between public and private hospitals. Noting that Newcomb Hospital was dedicated by its certificate of incorporation to serve the sick and injured public, and that it received certain public funds and tax benefits, the Court declared that the hospital held its powers "in trust for the benefit of the public." In the words of the Court, the purpose of a hospital is to "faithfully furnish facilities to members of the medical profession in aid of their service to the public." Thus, by breaking down the distinction between private and public hospitals, the New Jersey Supreme Court paved the way for later judicial imposition of procedural fairness requirements upon the private hospital.

Ruling on Dr. Greisman's complaint, the New Jersey Supreme Court declared that the bylaws' provision was void as being against public policy. The Court ordered the hospital to consider Dr. Greisman's application on its merits. A rejection of an application for staff privileges, the Court said, must be based on reasons legitimately related to the hospital's capacity to serve the health needs of the community.

The bylaws of private hospitals must embody the fundamental fairness requirements set forth by the New Jersey Supreme Court.

Further, "due process" requirements developed as a result of a court decision made in the wake of the Greisman case. In *Sussman v. Overlook Hospital*, 231 A.2d 389 (1967), the New Jersey Superior Court, Appellate Division, ruled that a private hospital has a duty to provide a fair hearing before it can reject a physician's application for staff privileges.

The scope of this right to a hearing was clarified by the Supreme Court of New Jersey in the case of *Garrow V. Elizabeth General Hospital*, 79 N.J. 549, 401 A.2d 533 (1979).

GARROW CASE

The Garrow case involved a suit brought by a board-certified pediatric surgeon against a private hospital which denied him medical staff privileges. The facts of the case reveal that Dr. Garrow was licensed in both New Jersey and New York and had served as director of pediatric surgery in a New Jersey hospital and as an associate clinical professor in a medical school. Dr. Garrow had published several articles in leading medical journals and was a fellow of a number of professional societies.

His application for medical staff privileges proceeded through various hospital committees in accordance with the

bylaws of the medical staff. While the other committees recommended favorably on his application, the Medical Organization Committee, whose responsibility was to make a final privileges' recommendation to the Board of Trustees, recommended that the application be denied.

The Medical Organization Committee based its adverse decision on the fact that the physician did not disclose his denial of medical staff privileges at another hospital, despite the fact that the application form of Elizabeth General Hospital specifically stated that such disclosure was required under penalty of rejection. The Medical Organization Committee also noted four (4) other reasons on which it based its rejection.

"A physician should not be required to forego legal representation at a fact finding hearing, the outcome of which may seriously affect his ability to practice his profession." (Garrow case)

The specific and detailed reasons for disapproval were documented in the Medical Organization Committee's notes and were given to the physician applicant. He also was advised that he had a right to a hearing before a committee chosen by the Board of Trustees in accordance with the hospital bylaws.

In advance of the hearing before the Board of Trustees, the physician applicant requested an opportunity to examine all of the documents in the hospital's possession which were material to the denial of his application for medical staff privileges. He also requested the opportunity to be accompanied by his attorney before the Hearing Committee of the Board of Trustees.

When the hospital refused to grant his requests, the physician applicant sued the hospital and petitioned the court to prevent the hearing from taking place. The hospital responded by charging that the physician's complaint should not be heard by the court until a final decision had been made by the Board of Trustees. The hospital reasoned that judicial proceedings would be unnecessary if the Board of Trustees approved the physician's application for medical staff privileges after the hearing.

The trial court found the hospital's reasoning persuasive and dismissed the physician applicant's complaint. He appealed and the Appellate Division reversed the trial court and noted that judicial intervention was necessary in order to protect the physician applicant's right to a fair hearing. The hospital further appealed this decision to the New Jersey Supreme Court.

The Supreme Court of New Jersey found that judicial intervention had not been warranted in the first place. The Court ruled that where hospital bylaws appear fair and where no constitutional issues are presented, internal hospital proceedings must be exhausted before an aggrieved physician can seek a remedy in the courts.

The Court further acknowledged that the hospital Board is supposed to have particular expertise in determining a physician's qualifications in relation to a hospital's facilities, needs and personnel. The Court noted that it would defer to the expertise of the hospital Board and would not intervene unless it was necessary to ensure that the hospital's decision to reject an applicant was based on reasonable grounds after a fair hearing had been held.

The Supreme Court of New Jersey pointed out in the Garrow case that the hospital hearing is a critical event in the physician's ultimate challenge to an adverse decision by the Board of Trustees. The hearing, however, need not be a full-scale adversary proceeding. The Court noted that the formal

rules of evidence which apply to courtroom trials would not be required. The Court said that reliable, relevant evidence, even though of a "hearsay" nature (i.e., information which someone has told someone else about the physician's professional conduct) can be considered at the hearing.

The Garrow case protected the physician applicant's interest by requiring the hospital to allow the physician prehearing access to relevant, underlying information upon which the hospital had relied in making its decision with regard to his application for privileges. The Court further ruled that the hospital would not be required to give all of its information to the physician applicant and could withhold that information which is not relevant or material to the hospital's decision to deny privileges.

Fundamental fairness dictates that the physician applicant be given an opportunity to respond to specific charges made against him. (Garrow case)

The Garrow court also ruled that a physician applicant has a right to be represented by legal counsel at the hospital hearing if he so chooses. The physician applicant's attorney may advise him during the course of the hearing, and may present favorable evidence on his behalf. Where the hospital presents adverse witnesses, the applicant's attorney will be permitted a limited right to cross-examine those witnesses.

In general, the New Jersey Supreme Court in the Garrow case has provided a safeguard to a physician applicant's civil rights by mandating that private hospitals afford the physician applicant an opportunity to challenge the hospital's adverse decision in denying him hospital privileges. In most cases, however, a court will not intervene in this process until after a hearing has occurred and a final decision has been rendered by the Board of Trustees of the hospital. Furthermore, if judicial intervention is permitted, it will be limited to a review of the record of the hearing to ensure that the hospital's decision was neither arbitrary nor capricious, and rested upon reasonable and sensible grounds.

CLOSED MEDICAL STAFFS

Can a hospital ever refuse to grant medical staff privileges to a physician applicant who is professionally well qualified? The answer well may be yes, depending on the physician applicant's abilities to fulfill his participatory responsibilities as a member of the hospital medical staff. For example, a large group of physicians may have privileges in several hospitals. They may be too spread out and may be unable to meet their clinical responsibilities due to their general unavailability. Some hospitals have granted privileges to physicians such as these and have found that they are unavailable to cover their own admitted patients when these patients experience emergency situations in the hospital.

Such a situation easily could be clinically and administratively intolerable. It may well be an acceptable argument that the hospital is able to refuse privileges to an apparently qualified physician applicant because of that applicant's apparent inability to handle his clinical responsibilities once privileges have been granted.

The question of whether a hospital can close its staff was addressed in the case of *Walsky v. Pascack Valley Hospital*, *supra*. In this case the hospital's Board of Trustees issued a moratorium prohibiting any new medical staff appointments unless the applicant met certain conditions. In order to be eligible for a staff appointment the applicant must have had a subspecialty needed by the hospital and must have agreed

to refrain from seeking staff privileges at other hospitals.

The facts reveal that the plaintiff physician had struck from his application the affirmation that he would not seek or accept an appointment to any other hospital medical staff. The plaintiff made known his intention to seek staff privileges at another hospital so as to be able to treat his partner's patients at the other hospital. The hospital granted the physician a hearing based on his claim that he had a limited subspecialty needed by the hospital.

"... this form of discriminatory treatment, wholly unrelated to patient care or the needs of the institution, is clearly violative of the Equal Protection Clause, which requires that all persons in like circumstances be treated alike, both as to privileges conferred and burdens imposed." (Walsky case)

He subsequently was denied staff privileges. The plaintiff physician sought judicial review of the hospital's final decision, alleging among other things that the moratorium invidiously discriminated against newly admitted members of the staff by denying them the right to seek other hospital affiliations while not imposing the same restriction upon the present staff. The plaintiff also argued that the moratorium was an arbitrary and capricious exercise of discretion on the part of the hospital board since the moratorium failed to accomplish its intended purpose, a reduction in bed occupancy rates. He also charged the hospital with failing to establish any ascertainable standards or criteria by which physicians may be admitted to the staff under the "subspecialty" exception, thus allowing the hospital to grant privileges based on mere whim or caprice.

The court confined its scope of review to a determination of whether the Board's action was reasonable and not arbitrary and capricious. Applying an equal protection analysis, the court ruled that where hospital action is exclusionary only as to some physicians and is not applied to all physicians equally, the action is unconstitutionally discriminatory. The court also noted that the only significant effect of continuing the closure of staff appointments was to confine control of the hospital's beds to its existing medical staff and to enhance their economic interests at the expense of other qualified physicians. The court found such a practice to be judicially intolerable.

In further examining the merits of the parties' claims, the court found that the moratorium could not and did not

alleviate bed occupancy problems. It further observed that the hospital's establishment of an undefinable classification of "subspecialties" for granting or denying the important economic benefits of medical staff privileges clearly violated public policy.

In summary, it safely may be said that New Jersey case law indicates judicial support of hospital policies and decisions affecting medical staff privileges where such policies and regulations reasonably reflect and implement a hospital's legitimate goal of promoting the health and welfare of the public at large.

CONCLUSION

What is the likelihood of a successful court attack by a physician upon an adverse-privileges decision rendered after a hospital hearing? The answer, of course, will depend entirely upon the facts of the particular case. If the hospital and medical staff have enacted procedurally fair and reasonable bylaws, rules and regulations, and have abided by them, the hospital's privileges decision probably will be upheld in court if it is found to be sensible and reasonable and not applied in an arbitrary or capricious manner. The aggrieved physician may be successful in court if a judicial review of the record of the hospital hearing shows that the hearing was conducted unfairly, or that the criteria upon which the hospital based its decision are against public policy or otherwise invalid.

It is clear that the courts have recognized that hospital medical staff membership is essential to most physicians. Also, courts generally have permitted private hospitals to retain a large measure of discretion in granting staff privileges. The New Jersey courts have taken a significant lead in providing some safeguards to protect the interests of physicians who apply for medical staff privileges.

These procedural safeguards must be embodied in the hospital and medical staff bylaws, rules and regulations. These matters always will be subject to judicial scrutiny in order to determine that they are fair and reasonable and have been applied to the particular facts of the case in a manner that is neither arbitrary nor capricious. Thus, if the total number of physicians increases relative to the total number of hospital beds, physicians and hospitals can expect more legal attention to be focused upon this important area of hospital privileges.

This information is compiled by the Schwartz Inter-National
Pharmaceutic and Therapeutic Drug Information Center of the Arnold
and Marie Schwartz College of Pharmacy and Health Sciences, Long
Island University.*

1. Can MHPG, a norepinephrine metabolite, serve to predict a response to tricyclic antidepressant?

Differences in urinary MHPG excretion, a major metabolite of norepinephrine (NE), have been advocated as useful for predicting tricyclic antidepressant (TCAs) response. It is proposed that depressed patients who exhibit low urinary MHPG levels respond better to TCAs that primarily enhance NE in the CNS such as desipramine (sold as Pertofrane®) and imipramine (sold as Tofranil®), and those who exhibit normal or elevated MHPG levels respond better to serotonin-enhancing TCAs such as amitriptyline (sold as Elavil®).^{1,5}

Maas *et al*⁶ found desipramine or imipramine responders excreted smaller amounts of MHPG than non-responders. Beckmann *et al*⁵ similarly indicated imipramine responders excreted lower MHPG than nonresponders. In addition, high MHPG excreters responded well to amitriptyline while low excreters didn't.

Sacchetti *et al*,⁷ in contrast, reported four of five men including two very low MHPG excreters responded to amitriptyline. Spiker *et al*⁸ found no correlation between MHPG excretion and amitriptyline response. They also indicated that the serotonin enhancer, amitriptyline, is metabolized to nortriptyline, an enhancer of NE. Imipramine, predominantly a norepinephrine enhancer, increases serotonin levels as well.¹

In conclusion, some evidence suggested that patients with low urinary MHPG responded better to imipramine or desipramine, while patients with normal or high urinary MHPG responded better to amitriptyline. It appears the NE and serotonin activity of the metabolites of TCAs may not have been considered adequately in formulating this widely accepted theory.

REFERENCES

1. Anon: *Facts and Comparisons*, 1980 ed. Facts and Comparisons, Inc., St. Louis, 1979, p. 903-913.
2. Maas JW: Biogenic amines and depression, *Arch Gen Psychiat* 32:1357-1361, (Nov) 1975.
3. Anon: *Physicians' Desk Reference*, 34th ed. Oradell, NJ, Medical Economics Co., 1980, p. 1215-1216.
4. Hollister LE, *et al*: Excretion of MHPG in normal subjects. *Arch Gen Psychiat* 35:1410-1415, (Dec) 1978.
5. Beckmann H, Goodwin F: Antidepressant response to tricyclics and urinary MHPG in unipolar patients. *Arch Gen Psychiat* 32:17-21, 1975.
6. Maas JW, *et al*: Catecholamine metabolism, depressive illness and drug response. *Arch Gen Psychiat* 26:252-262, 1972.

7. Sacchetti E, *et al*: MHPG, amitriptyline and affective disorders, a longitudinal study. *Int Pharmacopsychiat* 11:157-162, 1976.

8. Spiker DG, *et al*: Urinary MHPG and clinical response to amitriptyline in depressed patients. *Am J Psychiat* 137:1182-1187, (Oct 10) 1980.

2. Please provide information concerning the differences between prompt phenytoin sodium capsules and extended phenytoin sodium capsules.

The USP reclassified phenytoin sodium capsules as either extended phenytoin sodium capsules or prompt phenytoin sodium capsules and all phenytoin sodium capsules are now labeled as such. This differentiates between capsules having relatively slow dissolution rates and extended delivery, and those having more rapid dissolution rates and prompt delivery.¹ Extended phenytoin sodium capsules presently are available only in the form of Dilantin Kapseals® (Parke Davis), which dissolve in water to an extent of 35 percent in 30 minutes, while prompt phenytoin sodium capsules are all the generic phenytoin sodium products and dissolve to an extent of 85 percent or more in the same time period.²

While one-a-day dosage for adults with 300 mg Dilantin® (extended phenytoin sodium capsules) may be utilized in place of three divided 100 mg Kapseals®, administration of the prompt phenytoin sodium capsules on a once-a-day basis could result in phenytoin toxicity.^{3,4} As of July 1, 1980, regulations required that prompt phenytoin sodium capsules be labeled with the statement, "Not for once-a-day dosing."¹

When switching from a generic product to Dilantin Kapseals®, or vice versa, it is recommended that phenytoin blood levels be carefully monitored. Physicians should also specify, and pharmacists should ascertain, what form of phenytoin sodium capsules a patient is to receive.

*The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm. D.; H.L. Kirschenbaum, Pharm. D.; M.J. Berger, M.S., R.Ph.; D.M. Biondi, R.Ph.

REFERENCES

1. Anon: Extended phenytoin sodium capsules, *USP XX*—Prompt phenytoin sodium capsules, *USP XX*, in *USP Update*, Vol 2, No. 3, (May-June) 1980.
2. Anon: Monographs on extended and prompt phenytoin sodium capsules, in *USP XX—NF XV*. Rockville, Md., U.S. Pharmacopeial Convention, Inc., (Jul 1) 1980, 621-622.
3. Abramowicz M (ed): Dilantin® vs. generic phenytoin sodium. *Med Let* 22:49-50, (June 13) 1980.
4. Anon: Monographs on extended and prompt phenytoin sodium capsules. *USP—Dispensing Information*. Rockville, Md., 1980, p. 392.

3. Is there an interaction between clorazepate and antacids?

Clorazepate (sold as Tranzene® and Azene®) has similar antianxiety activity to diazepam (sold as Valium®). Reports in the literature indicated that antacid therapy significantly decreased absorption of clorazepate.¹ The proposed mechanism of interaction is impaired conversion of the drug to its active form, desmethyldiazepam, as a result of increased stomach pH.² This interaction recently has been refuted in the literature.^{3,4}

Earlier *in vitro* studies that suggested impaired conversion of desmethyldiazepam from clorazepate have not held up in recent clinical trials and *in vivo* conversion appeared to occur despite the absence of gastric acid.³

Chun *et al*⁴ in a randomized, three-period cross-over design investigated the effect of magnesia and alumina suspension on clorazepate in 15 normal, healthy adults who ingested the drug alone and with single and multiple doses of antacid. A trend to slower absorption and lower peak desmethyldiazepam plasma levels initially occurred when clorazepate was administered with antacid. However there were no significant differences in the extent of total absorption. Clorazepate's plasma levels were similar for all treatments and urinary excretion pattern was likewise comparable. Plasma elimination half-lives of clorazepate and desmethyldiazepam were not affected by antacid therapy.

In conclusion, the extent and completeness of absorption of clorazepate appears not to be significantly influenced by concomitant antacid therapy. It appears that clorazepate may be confidently prescribed with antacids.

REFERENCES

1. Zisook S, DeVaul R: Prescribing anxiolytics. *Drug Therapy* 9:41-54, (Nov) 1979.
2. Greenblatt DJ, Shader RI: Pharmacokinetic understanding of antianxiety drug therapy. *South Med J* 71:2-9, 1978.
3. Ochs R, *et al*: Effect of age and Billroth gastrectomy on absorption of desmethyldiazepam from clorazepate. *Clin Pharmacol Ther* 26:449-456, 1979.
4. Chun, ANC, *et al*: Effect of antacids on absorption of clorazepate. *Clin Pharmacol Ther* 22:329-335, 1977.

Erratum

Please note that there is an error in the "Therapeutic Drug Information" item which appears on page 914 (V. 77, No. 13) of the December 1980 issue of *The Journal*, MSNJ. In the discussion on influenza vaccine, the word "Poland," line 9 of the righthand column, should not appear. The capital letter "N" in line 15 of the same column should be followed by an inferior "1."

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physicians Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

Cost Containment and Safety for Office Surgery

The problems of limiting costs for surgery and hospitalization, while providing safety for the patient, are outlined in this article which describes the features of cost containment with safety in office plastic surgery. The application of these benefits are described in detail. The safety factor is largely contingent upon the services of an anesthesiologist working with the plastic surgeon in his office surgical suite.

Physicians must produce unique solutions to the problems of increasing cost of hospital care or provide an alternative method of treatment. The need to lower expenses is most acute for medical care that many insurance carriers may cover only minimally or not at all. This report covers one such solution in the specialized area of *plastic and cosmetic office surgery*.

It is perfectly feasible to attain significant cost reduction while maintaining full safety for the patient. By careful purchase of supplies and utilization of personnel, at least 50 percent of the hospital, operating room and anesthesia expenses for surgery have been saved in an appropriate office facility. Compared to local hospital expenses at today's rates, surgery as an outpatient for a one and one-half to two-hour operation costs \$250 or more for the anesthesiologist, \$400 to \$600 for hospital care with "Day Accommodation Room," operating room, recovery room, drugs and supplies. By contrast, at present rates, the overhead expense for comparable service charged to the patient in the office surgical suite is \$300 to \$400, including the anesthesiologist's fee. Moreover, we feel we have found a safe manner in which to operate on patients outside a hospital. It is not simply a matter of putting an operating table into a treatment room and hoping for the best; considerable planning and preparation are necessary.

One year ago an office surgical suite was designed and built following the guidelines of the American College of Surgeons for operating room construction. The surgeon and the designer studied many preexisting units around the country to incorporate their most appropriate features. In such an undertaking, one discovers the importance of such factors as: filtered ventilation, non-flaking ceilings, seamless floors, and washable vinyl walls. While the total area need accommodate only three or four patients a day, it is necessary to construct sections to provide reception and pre-operative areas, operating and postoperative observation rooms. Additional space is required for anesthesia and resuscitation equipment, lockers, sterilization and preparation equipment and storage. The surgeon must provide facilities and must staff them in a manner comparable to the hospital. Periodic and regular checking of resuscitative and all electrical equipment is required.

We perform a large range of operations in the surgical suite that do not require general anesthesia, transfusion, or unusual supportive measures. The procedures generally are performed on the face, breasts and extremities. The key to a comfortable and safe operation on a patient, who later will walk out of the office, is proper use of anesthetics with continuous monitoring. We perform our operations under local anesthesia combined with intravenous sedation and analgesia *monitored by an anesthesiologist*. While "just a quick shot of Novacaine®" might be fine for the removal of a small surface lesion, it is not adequate for a longer meticulous operation. The enlargement of breasts, a facelift, or release of a Dupuytren's hand contracture, for example, require a different kind of anesthesia.

The surgeon must select candidates for elective surgical procedures in the office very carefully. After a patient has had a physical examination and psychological evaluation, his mental attitude under local anesthesia still remains a prime concern. The patient's requirements are: (1) freedom from anxiety, (2) analgesia during the injection of a local anesthetic, (3) freedom from nausea or vomiting, (4) comfort during surgery and (5) rapid return to the normal state. We provide for these needs in multiple ways, e.g., comfortable surroundings and empathetic personnel and appropriate medications, which are suitably monitored.

The selection of medications for use with the local anesthetic is quite important. We use these agents primarily for reduction of anxiety. We avoid the routine administration of tranquilizers, sedatives and barbituates and most narcotics because they do little to allay anxiety while bearing potential depressant effects. Premedication with drying agents is not necessary and may produce untoward effects. A dissociative analgesic (Ketamine®) and/or a short acting reversible narcotic combined with diazepam (Valium®) is our usual "intravenous cocktail." We do not hesitate to use compatible additional analgesic agents as needed. The timing of administration and the introduction of analgesics and anesthetics, while watching the patient's reactions, constitute the art of this anesthetic technique. Throughout the entire operation, the anesthesiologist monitors the patient's progress utilizing the mental status, pulse, blood pressure and continuous electrocardiographic tracing.

A typical example of our technique follows:

An otherwise healthy 49-year-old female has been scheduled to undergo bilateral blepharoplasties for moderately severe, puffy and droopy eyelids. She is given a hypnotic for sleep the night before surgery. Two hours prior to surgery, the patient takes 10 mgs of diazepam orally with a light breakfast of toast and coffee. On arrival at the office surgical suite, the patient exchanges clothes for a gown and may be

given an additional 10 mgs of diazepam orally 30 to 45 minutes prior to surgery, if she expresses anxiety. The patient then enters the operating room and is positioned. While the surgeon scrubs, the anesthesiologist starts an intravenous infusion of glucose and water with a large bore catheter and administers diazepam slowly, while monitoring, until the patient's speech begins to slur. This may require total doses in the range of 5 to 20 mgs. of diazepam, depending on the patient's tolerance and prior medication. Once satisfactory response has been obtained and the patient has been prepared and draped by the surgical team, she is ready for the injection of the local anesthetic. This is usually one percent Lidocaine® with adrenalin one to 200 thousand dilution. Just prior to infiltration, the anesthesiologist administers approximately 40 mgs. (0.5 mgs. to 1.0 mgs. per kgm.) Ketamine Hcl®, over one minute. It is interesting that the unpleasant hallucinogenic effects of Ketamine® given alone are not usually seen when combined with diazepam as outlined here. During the operation, supplementation may be done with additional Ketamine®, Valium®, Fentanyl®, or other. By the end of one to one and a half hours the surgery has concluded and the patient is alert and comfortable. She is transferred to the recovery room where iced compresses are placed on the eyes and vital signs monitored by a nurse, supervised by the anesthesiologist. Typically the patient is discharged, walking with an adult relative or friend two hours later. The surgeon gives the patient a prescription for a non-narcotic analgesic, but it is used rarely.

Infinite variations of this scenario are possible. The anesthesiologist and surgeon jointly may select different medications or anesthetics. For example, in our selection of agents for breast augmentation, we now use two kinds of local anesthetics, one a long-acting form which helps to alleviate postoperative discomfort. During the operative dissection, before placement of the breast implant, the anesthesiologist administers nitrous oxide and oxygen by mask, supplementing the intravenous medication.

We are well aware that some surgeons operating in hospital outpatient departments and in their offices act as both surgeon and anesthesiologist. In our opinion this is a dangerous practice. No matter how well trained in cardiopulmonary resuscitation are the surgeons and their staff and no matter how sophisticated is their equipment, the potential for disaster is ever present. There is no need to expose the patient to unnecessary risks when drug administration and monitoring of vital signs can be done by the

individual most capable, i.e., the anesthesiologist. While we have encountered *no* occasion thus far requiring use of our suction machines or resuscitation equipment, we know that we may have such a situation. The anesthesiologists have used oxygen, Narcan® and other corrective medications, when necessary during the course of operations, without need to stop or prolong the operations. The operations proceed because the patient's untoward reactions are detected and treated quickly by the anesthesiologist. In such a partnership, the surgeon can perform unhurried careful surgery free from having to assume a dual role.

DISCUSSION

We have presented our approach to cost containment and safety in an office surgical suite. This report would not be complete without a comment on the illogical approach of some insurance carriers. While local and neighboring state workmen's compensation and "no fault" automobile insurance carriers are glad to pay the surgical fees with reduced overhead costs for the use of an outpatient operating suite, others are not so enlightened. For example, our New Jersey Blue Shield will pay part of the surgical fee (for a non-cosmetic procedure) but New Jersey Blue Cross will not pay the overhead fees. Similarly, Medicare seems confused. Although its sister federal agency—the Veterans Administration—will pay *all* fees in the operating suite, Medicare will not pay *anything*. This prohibits the further use of such a facility by other physicians, e.g., general surgeons or ophthalmologists whose patients need basic insurance coverage. Some carriers would rather pay over twice as much for the same operation in the hospital, yet government and health care planners continuously plead for cost containment. We must hope this situation will improve in the future as the lay public and medical profession become more aware of the alternatives.

R. Bloomenstein, M.D.
A. Mauro, M.D.
Englewood Hospital

References

- ¹ Levy ML, Coakley CF: In and out surgery, first year. *So Med J* 61:995-998, 1968.
- ² Cohen D, Dillion JB: Outpatient anesthesia. *JAMA* 196:1114-1116, 1966.
- ³ Beekhuis GJ, Kahn DL: Anesthesia for facial cosmetic surgery: Low dosage Ketamine®-diazepam anesthesia. *Laryngoscope* 88:1709, 1978.

YOUR CONGRESSMAN SPEAKS

A Whole New Ballgame

THE HONORABLE FRANK J. GUARINI, Washington, D.C.*

Any attempt to forecast future Congressional action with respect to medicine and health is a risky business. Nonetheless, certain signposts on the road ahead already can be glimpsed. The Congress, as with all institutions, must respond to the pressures of the times. And the present and its pressures are painfully clear to all of us.

With continuing, intractable inflation coupled with an uncertain economy, the 97th Congress is not apt to establish new health programs or to broaden old ones. With a new Republican president and a Republican-controlled Senate, there has been a dramatic shift in priorities and legislative approaches as well.

The balance-the-budget fight in the Congress has truly taken its toll. Lawmakers from both sides of the aisle have faced the gloomy prospect of cutting programs, including health programs, that are favored and popular. A number of long-term proposals such as national health insurance appear moribund. And an uphill fight faces any attempt to expand existing programs in any area unless a concomitant cost savings clearly and convincingly can be demonstrated.

As the word has gone out that the old spending style is out of sync, there have been resounding battles in the appropriations and authorization committees. While little has been felt to date in the health care area, the pinch eventually will come as budgetary constraints work their way through the health care system.

Preliminary battles occurred over the Child Health Assistance Program which would have provided a comprehensive health care delivery system for children and pregnant women. As recently as two years ago, it would have been unthinkable to delay such an obviously meritorious program, but deferred it was as the Senate adjourned without taking action on the House-passed bill.

Similarly, several modest improvements in the Medicare and Medicaid programs were delayed or removed during consideration of the budget reconciliation package by Senate and House conferees.

A particularly illuminating skirmish took place when conferees on the reconciliation bill dropped a provision for reimbursement of pneumococcal vaccinations under Medicare despite a showing of impressive savings in health expenditures over the long run. An attempt later was made to restore reimbursement in separate legislative action. That 11th hour effort—just prior to adjournment—was successful. However, it illustrates the consequences of rigid adherence to specific savings targets.

The present economic straits we are experiencing have

heightened Congressional aversion to the development of new programs. This resistance to new initiatives has coincided with a growing disenchantment in Congress with the results of existing programs and has underlined the need to get the old programs working better before venturing on to new ones. Health care programs have not—and will not—escape this scrutiny.

An effort to right the wrongs in old programs is exactly what you will be seeing in the next few years. Bolstered by the growing costs of health programs and a seemingly clear directive from the American people to reduce government spending, Congress is going to go back over existing health programs with a fine-tooth comb searching not only for waste and fraud, but for better and more efficient ways to accomplish program goals.

One important concept now making headway is the idea that health care costs can be managed better by increasing competition in the delivery of services. This approach is in direct opposition to the regulation and amendment strategy which has been a part of the federal scene for so many years.

This change of emphasis has been on the way for some time. It gradually has picked up speed as new members, committed to reducing government spending and regulation, have replaced the advocates of expansionist government policies. The November election sped up the process beyond expectations. Only six months ago, my prediction would have been that the legislative emphasis in the 97th Congress and in the foreseeable future would remain fixed upon finetuning the existing programs and regulatory apparatus rather than taking a turn toward consideration of new approaches in health care financing. The possibility of substantive reform now looms before us.

It seems timely for this type of transition in thinking to take place. Recent studies have indicated that regulation costs our citizens in excess of \$100 billion annually. According to the New York Hospital Association, 25 percent of the cost of a day's hospital stay is directly attributable to compliance with local, state and federal regulations.

Congress is becoming increasingly concerned about such costs and is finding that the bureaucracies set up to monitor programs are unable to accomplish the tasks of adequately policing costs and deterring waste and fraud without creating burdensome and costly procedures of their own.

The competition concept has developed rapidly and has

*Congressman from the 14th District; member Committee on Ways and Means. He may be addressed at 1123 Longworth Building, Washington, D.C. 20515.

gained some impressive backers in Congress. Among its chief proponents are recently elected members who are challenging old assumptions in order to find better and more efficient management systems from programs whose objectives the public has deemed worthy but which are ready for administrative streamlining.

Last June, Congressmen Richard Gephardt and David Stockman introduced H.R. 7527, the National Health Care Reform Act, one of the most innovative of the pro-competition proposals.

H.R. 7527 would permit consumers to select health care coverage from an array of approved health insurance plans and tax credit options. Consumers would be given an incentive to shop for the best coverage at the lowest price because of the direct tie between cost and coverage. Under the Gephardt-Stockman proposal, consumers would be less likely to be shielded from the financial ramifications of their choices by third party payers.

For health care providers, in exchange for deregulation of the health care industry, there would be the challenge of providing the best service at the lowest possible cost. Pro-

viders would be required to lay aside long-held assumptions about an unending stream of government and insurance dollars to pay for services and facilities. Instead, providers would be placed in direct competition with each other for customers and they would need to respond to consumer choice rather than regulatory or legislative mandates.

The Gephardt-Stockman proposal, now in outline form, is bound to be more fully explored during the 97th Congress. Stockman, the director of the Office of Management and Budget in the new Reagan Administration, is in a prime position to push such an initiative from the executive branch. Meanwhile, Congressman Gephardt is likely to continue to advocate the competition concept from his congressional forum as a member of both the Ways and Means and Budget Committees.

Whatever the next few months bring, it is increasingly evident that the requisite commitment is present in Congressional circles for a thoughtful reexamination of the premises upon which health care is financed. If this commitment holds, the new session of Congress will be interesting and controversial indeed.

Housing Application—Meadowlands Hilton Annual Meeting, MSNJ—May 15-19, 1981

Please Reserve: _____ Single _____ Double _____ Twin _____ Suite

Arrival: (date) _____ at (time) _____

Departure: (date) _____ at (time) _____

Name _____

Address _____

City _____ State _____ Zip Code _____

If double or twin name of person joining _____

Single: \$56

Twin: \$67

Double: \$67

Suite: \$150 and up

If range of rates is offered and rate requested is not available, the next available rate will be assigned. Reservations must be received no later than two (2) weeks prior to the opening date of your meeting and will be held until 6 p.m. on day of arrival unless otherwise specified.

(New Jersey Sales Tax - 5%)

Complete and mail this application to: Front Office Manager
The Meadowlands Hilton
Two Harmon Plaza
Secaucus, New Jersey 07094

Adolescent Pregnancy and Nutrition

BETTY RUTH CARRUTH, Ph.D., Dallas*

Changes in the sexual behavior of teenagers in the United States in recent decades involve all segments of the population and the consequences of these behaviors are having an impact on the health care system and the health professional who provides services. Zelnik *et al.* reported that one in five females have intercourse by age 16 and one in ten get pregnant before age 17. Over one-third of the females who are sexually active premaritally have a premarital pregnancy before reaching age 19, with one-quarter becoming pregnant by age 17.¹

For the years 1957 to 1974, the overall fertility rate decreased for females ages 15 to 17 years; however, the number of adolescent girls almost doubled in that period so the actual number of live births to that age group has changed little.² The fertility rates for females less than 15 years have risen. As could be anticipated, 85 percent of the births to girls 15 years and younger were illegitimate as compared to 23 percent of those born to girls age 19. Live births to girls ages 15 to 17 years increased by more than 20 percent during the years 1966-1975.^{3,4}

SOCIOLOGICAL IMPLICATIONS

The pregnant teenager has less opportunity to develop self-esteem, gain skills for economic independence, and to separate from the family unit or environment which contributed to behaviors that resulted in a pregnancy.⁵ Sugar described a syndrome of failures characteristic of many pregnant adolescents who become more dependent on the family, welfare systems and child-care assistance, and who frequently are abandoned by the putative father or husband.⁶

HEALTH IMPLICATIONS OF ADOLESCENT PREGNANCY

In terms of health risks, the younger the mother the greater the risk of having a low birth-weight infant with the sequela of possible abnormalities of development, inadequate bonding of mother and child, and potential for child abuse and neglect.⁷ In 1979, the Committee on Adolescence of the American Academy of Pediatrics published a "Statement on Teenage Pregnancy."⁸ The main complications of teenage pregnancy were considered to be pre-eclampsia and low birth-weight infants. The time interval between onset of menses and conception was a risk factor because conception two years or less after onset of menses was associated with a higher incidence of low birth-weight infants, irrespective of social class. The etiology of pre-eclampsia is unknown and develops as the onset of hypertension, albuminuria or edema between the 20th week of pregnancy and the first week postpartum.

Other factors, smoking, alcohol and drug use, socioeconomic status and nutrition, influenced the pregnancy outcome in all age groups. In addition, early and adequate prenatal care, as well as an absence of preexisting chronic health problems, enhanced pregnancy outcome. Generally,

teenagers seek prenatal care later and have fewer total visits than older women of childbearing age. Therefore, the biological maturity, the amount and frequency of prenatal care, as well as the overall lifestyle of adolescents, place them at a greater risk than women in the 20 to 24 age group.

NUTRIENT NEEDS DURING PREGNANCY

Both pregnancy and adolescence are periods of increased requirements for energy and for some 40 essential micro and macronutrients. The most rapid rate of skeletal and muscle growth for adolescents is prior to menarche. Following menarche, the rate of tissue synthesis rapidly declines, reaching adult levels within two to three years.⁸ Thus, if a teenager has good nutritional practices prior to pregnancy, the health risks are reduced for both her and the infant.⁹

RECOMMENDED DIETARY ALLOWANCES (RDAs)

The RDAs represent a norm for estimating nutrient allowances of groups. They often are applied improperly to food intake records of individuals. They also are based on chronological age rather than maturity. A review of the 9th edition reveals the limited scientific data upon which allowances for nonpregnant and pregnant adolescents are based.¹⁰ Epidemiological surveys describe practice but do not establish nutrient requirements. Thus, in most part, the RDAs are extrapolations from infant data and/or adult values. Energy and nutrient allowances for pregnancy are additive to those for the nonpregnant female.

In estimating nutrient needs, there is evidence that protective and unexplained mechanisms are involved in regulating both energy stores and plasma levels of most nutrients during pregnancy. According to Hytten,¹¹ the mechanisms are unknown and are not explained on the basis of dietary deficiencies or malabsorption, e.g., the fetus may be protected from vagaries associated with maternal diet except in extreme malnutrition. However, if a diet inadequate in calories and other nutrients is supplemented, the result is bigger infants and thus reduction of the incidence of low birth-weight infants.

PREPREGNANCY WEIGHT AND GAIN DURING PREGNANCY

Low maternal weight gain during pregnancy correlates with a higher incidence of low birth-weight infants and higher mortality rates among neonates born to teenagers.¹² In a study of the relationship between weight gain and perinatal mortality, the optimal weight gain for an overweight mother was about half that for a very thin mother.¹³ A total weight gain of 24 pounds is essential to adequate fetal development⁹ with a recommended weight gain of about 20

*Reprinted with permission of *Contemporary Nutrition* 5:6 (June) 1980, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Carruth is Director of Nutrition, University of Texas Health Science Center, Dallas.

pounds occurring in the last half of pregnancy.¹²

Adolescents may diet in order to minimize the obligatory gain associated with the increasing maternal and fetal weight gain of pregnancy. Restrictive calorie intakes may result in ketonemia with subsequent ketosis, a condition ill-tolerated by the fetus and which may result in impaired neurological development.¹² Emphasis should be placed on the value of a good diet during pregnancy and the modification of food choices to contribute to better health postnatally.

For the pregnant teenager who is physically immature or is underweight, the rate and total amount of weight gain is greater than for the more mature female and energy costs are additive to those of pregnancy. In a controlled study, Blackburn and Calloway compared energy intake and expenditure of pregnant and nonpregnant girls. They estimated expenditures of sedentary pregnant adolescents as about 2,300 Kcal/day.¹⁴

In a review of reported energy intakes of pregnant women in the United States, Australia and the Soviet Union, it was found that (1) energy intake was frequently less than recommended, and (2) energy intake tended to remain constant throughout gestation.¹⁵

Comparing these findings to data from the Health and Nutrition Examination Survey (HANES) for United States teenagers shows similar results.¹⁶ Females ages 12 to 14 consumed about 1,900 Kcal/day and ages 15 to 17 consumed about 1,750 Kcal/day. An addition of 300 Kcal/day for pregnancy to the usual energy intake of 1,750 results in 2,050 Kcal/day. This is far below the recommended energy allowances of 2,700 Kcal/day for pregnant girls ages 11 to 14 and 2,400 Kcal/day for ages 15 to 18.⁹ If energy intakes tend to remain constant throughout pregnancy, a low initial intake provides inadequate calories for fetal and maternal needs. Early evaluation of prepregnancy weight and calorie balance are essential factors of a nutritional assessment.

DIETARY DEFICIENCIES

The most frequently reported deficiencies are calcium, iron and vitamin A,¹⁷ as well as folacin, riboflavin (B₂) and pyridoxine (B₆) in some groups. Most of the calcium consumed during pregnancy is accumulated in the fetus. During pregnancy, iron, vitamin A and folacin are essential for hematopoiesis. In addition, tissue synthesis requires energy and vitamins B₂ and B₆.

Recent surveys indicate that girls ages 12 to 14 years consume on the average about 75 percent of RDAs for calcium and older teens ages 15 to 17 about 66 percent. A daily intake of 1200 to 1600 mg/day of calcium is recommended.⁹

Iron and folacin supplementations have changed very little in the past decade. The increased requirements for iron during pregnancy cannot be met by the iron content of diets eaten by most teenagers. Thus, 30 to 60 mg/day of elemental iron and 300 to 500 mg/day of folacin usually are prescribed.

Inadequate dietary protein is uncommon unless the diet is also inadequate in calories and other nutrients. Many of the fast foods consumed by adolescents are relatively high in protein. An analysis of four fast-food meals for protein, vitamins A and C and iron indicated the following: 16 to 43 g of protein, 21 to 725 I.U. vitamin A, 12 to 29 mg vitamin C, and 3-7 mg iron.¹⁸ A fast-food meal could provide over one-half of the protein allowance. Allowances for pregnancy should equal the nonpregnant allowances plus 30 g/day, which is about 75 g/protein/day.

VEGETARIANISM

Teenage vegetarians may be at a risk for deficiencies of intake for energy, protein, iron and vitamins D, B₂, B₁₂. In addition, calcium, zinc, magnesium and iodine may be inadequate for the increased needs of pregnancy.¹⁹ It is reported that naturally occurring phytates and oxalates found in cereals, fruits and vegetables bind iron, zinc and chromium and reduce the bioavailability,²⁰ however, this is a controversial issue and many studies are in progress.

These pregnant adolescents may be especially susceptible to zinc deficiencies because of maternal and fetal needs. Studies in human and experimental animals indicate that abnormal labor and difficult childbirth were associated with lower levels of plasma zinc.²¹ The rapid pre-menses growth spurt and sexual maturation increase zinc requirements²² and are in part responsible for subsequent development of zinc deficiencies during pregnancy.

CONCLUSIONS

The incidence of teenage pregnancies is increasing. The major risks of these pregnancies are low birth-weight infants and pre-eclampsia and their related problems. To reduce these risks, emphasis should be placed on providing optimal energy and nutrient intakes to promote adequate maternal weight gain and fetal development. Known dietary deficiencies should receive special emphasis on counseling the pregnant adolescent.

REFERENCES

1. Zelnik M *et al*: *Fam Plann Perspect* 11:177-183, 1979.
2. National Center for Human Statistics, *Fertility Tables for Birth Cohorts by Color, United States 1979-1973* U.S. Government Printing Office, Washington, D.C., 1976.
3. Natality statistics, teenage childbearing, United States 1966-1975, *Monthly Vital Statistics Report*. National Center for Health Statistics, Vol. 26, No. 5 (suppl.), 1977.
4. Trends in illegitimacy, United States 1940-1965. *Vital and Health Statistics*. National Center for Health Statistics, Series 21, No. 15, 1968.
5. Lorenzi M, *et al*: *Adolescence XII* 14-22, 1977.
6. Sugar Max: *J of Youth and Adol* 5:251-269, 1976.
7. Committee on Adolescence. *Pediatrics* 63:795-797, 1979.
8. McGanity WJ: in Moghissi KS and Evans TN (eds): *Nutritional Impacts on Women*. Hagerstown, Harper and Row, 1977.
9. Task Force on Adolescent Pregnancy of the American College of Obstetricians and Gynecologists. *Adolescent Perinatal Health*, 1979.
10. Food and Nutrition Board. *Recommended Dietary Allowances*, 9th edition. National Academy of Sciences, 1980.
11. Hytten FE: *Postgrad Med* 55:259-302, 1979.
12. ———, Maternal weight gain and the outcome of pregnancy. *Nutr Rev* 37:318-320, 1979.
13. Naeye RL: *Am J Obstet Gynecol* 135:3-9, 1979.
14. Blackburn, ML and Calloway, DH. *JADA* 65:24-30, 1974.
15. Appel JA, King JC: *Family and Community Health* 1:7-18, 1979.
16. Dietary intake findings, United States 1971-1974. *Vital and Health Statistics*, Series 11, No. 202, DHEW Pub. No. (HRA) 77-1647, U.S. Government Printing Office, Washington, D.C., 1977.
17. *Food Consumption Profiles of White and Black Persons Aged 1-74 years*. United States 1971-1974, DHEW Pub. No. (PHS) 79-1658, U.S. Government Printing Office, Washington, D.C., 1979.
18. Kresina M: *J Curr Adol Med* 2:26-28, 1980.
19. Dwyer Johanna: Vegetarianism. *Contemporary Nutr* 4:6 Minneapolis, General Mills, Inc., 1979.
20. Mertz Walter: Trace elements. *Contemporary Nutr* 3:2 Minneapolis, General Mills, Inc., 1978.
21. Underwood EJ: in *Trace Elements in Human and Animal Nutrition*, 4th edition. New York, Academic Press, 1977.
22. Butrimoritz, GP, Purdy WC: *Am J Clin Nutr* 31:1409-1412, 1978.

Report of the Nominating Committee

Offices To Be Filled by Election 1981 Annual Meeting

Alfred A. Alessi, M.D., Chairman

Office	Term	Nominee and County
President-Elect	1 year	Howard D. Slobodien, M.D., Middlesex
1st Vice-President	1 year	Alexander D. Kovacs, M.D., Union
2nd Vice-President	1 year	Frank Y. Watson, M.D., Essex
Trustees:		
1st District	3 years	Douglas M. Costabile, M.D., Union
1st District	3 years	William Greifinger, M.D., Essex
2nd District	3 years	John J. Crosby, Jr., M.D., Hudson
2nd District	3 years	Michael R. Ramundo, M.D., Passaic
3rd District	3 years	Frank Campo, M.D., Mercer
3rd District	3 years	Palma E. Formica, M.D., Middlesex
4th District	3 years	John P. Kengeter, M.D., Ocean
Judicial Councilors:		
1st District	3 years	Gabor Somjen, M.D., Morris
4th District	3 years	Frederick W. Durham, M.D., Camden
AMA Delegates:		
	1 year	Myles C. Morrison, Jr., M.D., Morris
	2 years	Edward A. Schauer, M.D., Monmouth
	2 years	William J. D'Elia, M.D., Monmouth
AMA Alternate Delegates:		
	2 years	William E. Ryan, M.D., Mercer
	2 years	Howard D. Slobodien, M.D., Middlesex
	2 years	James H. Spillane, M.D., Warren
	2 years	Frank Y. Watson, M.D., Essex
Delegates and Alternate Delegates to Other States		
New York:		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	F. Sterling Brown, M.D., Atlantic
Connecticut:		
Delegate	1 year	Merton L. Griswold, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation:		
5th District	3 years	Robert F. Nunn, M.D., Cape May
6th Member	3 years	Howard H. Lehr, M.D., Union
Medical Services:		
5th District	3 years	John J. Pastore, M.D., Cumberland
6th Member	3 years	Frank A. Wolf, M.D., Warren
Mental Health:		
5th District	1 year	Friedrich K. Racke, M.D., Cumberland
3rd District	3 years	Joseph J. Kline, M.D., Mercer
6th Member	3 years	Joseph P. Cillo, M.D., Union
Public Health:		
5th District	3 years	Samuel C. Ingraham, II, M.D., Cape May
6th Member	3 years	Patrick J. McGovern, M.D., Hudson
Public Relations:		
2nd District	3 years	Vacancy
5th District	3 years	John J. Pastore, M.D., Cumberland
Standing Committees:		
Annual Meeting	3 years	Arthur C. Dietrick, M.D., Burlington
Auxiliary Advisory	3 years	J. James Pegues, M.D., Burlington
Finance and Budget	3 years	Harry M. Carnes, M.D., Camden
Medical Defense		
and Insurance	3 years	E. Arthur Kratzman, M.D., Union
Medical Education	3 years	Edwin W. Messey, M.D., Burlington
Publication	3 years	Dirck L. Brendlinger, M.D., Burlington

Amendments on Requirements for Issuing a Prescription

Board of Medical Examiners' Rule 13:35-6.6

Edwin H. Albano, President of the Board of Medical Examiners in the Division of Consumer Affairs in the Department of Law and Public Safety, pursuant to authority of N.J.S.A. 45:9-1 et seq., proposes to amend the rule setting forth requirements for prescriptions to include notice of generic drug availability to patients by a person possessing a plenary license to practice medicine and surgery or a podiatrist.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

13:35-6.6 Requirements for issuing a prescription

(a) Physicians who possess a plenary license to practice medicine and surgery and podiatrists who issue prescriptions for medication shall advise all patients by adequate notice, such as but not limited to a sign or pamphlet in the waiting room of the practitioner's office, that a request of the practitioner may be made by the patient to substitute a generic drug for any prescribed medication.

(b) [(a)] Physicians and podiatrists shall provide the following on all prescriptions.

1. Full name, age and address of patient;
2. Prescriber's full name, address, telephone number and proper degree designation as appears on prescriber's license;
3. Prescriber's [BNDD] DEA number when required for the dispensing of controlled dangerous substances. (Controlled Dangerous Substances Act of 1970);
4. Date of prescription;
5. Name, strength and quantities of drug or drugs to be dispensed;
6. Adequate instruction for the patient (P.R.N. or "as directed" alone is not sufficient);
7. Number of refills permitted or time limit for refills or both;
8. Signature of prescriber;
9. When preprinted prescription blanks are not available full name of the prescriber must be printed or stamped in block letters under the signature of prescriber;
10. Every prescription blank shall be imprinted with the words "substitution permissible" and "do not substitute" and shall contain space for the physician's or podiatrist's initials next to the chosen option, in addition to the space required for the signature by paragraph 8 above.
11. In no instance shall a physician or podiatrist utilize a prescription form which includes preprinted information such as, but not limited to, language, initials or other indications to discourage or prohibit substitution, which a prescriber may prohibit only by initialing or writing "do not substitute" on the individual prescription.

[10.] 12. In no instance shall a physician or podiatrist sign a blank prescription form which does not conform with the above standards.

(c) [(b)] Failure to comply with this ruling will subject the physician to disciplinary sanction in accordance with the Medical Practice Act.

(Filing date—September 12, 1979)

B.M.E. Rule 13:35-6.6—The Prescription Blank

All physicians are reminded that standard prescription blanks are required in New Jersey. They must include notice of generic drug availability. The approved form of the blank is as follows:

N.J. Physician, M.D.
1001 State Street
Trenton, N.J. 08618

DEA No. NJ12345

Name _____ Age _____

Address _____ Date _____

R

Substitution Permissible _____ initial Do Not Substitute _____ initial

Refill _____ M.D. _____

You should be aware that failure to initial the “do not substitute” part makes it mandatory for the pharmacist to substitute, if an approved generic drug is available and the patient accepts the generic substitute.

DOCTORS' NOTEBOOK

Trustees' Minutes December 21, 1980

A regular meeting of the Board of Trustees was held on Sunday, December 21, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Membership ... Noted that MSNJ membership as of November 30, 1980 was 9,306 (an increase of 26 dues-paying members since October), 923 of whom are dues exempt and 617 emeritus.

... Noted that AMA records show a total New Jersey membership of 6,278 as of November 30 (4,789 dues paid, 1,489 exempt). The AMA includes emeritus members in the regular exempt category.

Subordinate Loan Payments ... Noted that Heaney and Associates, tax counsel, will, on request, send a report on the status of the litigation contesting the IRS determination to deny the deductibility of subordinate loan payments made to the Medical Inter-Insurance Exchange of New Jersey and that a letter will go to all members of the Exchange outlining the position maintained by tax counsel.

Radiological Regulations ... Noted that arguments have been completed in the litigation opposing the State Board of Medical Examiners' ruling on the provision of mandatory radiological services to chiropractors. The opinion of the Appellate Division is pending.

Limited Certification of X-ray Technicians ... Agreed that legislative efforts to broaden the scope of the limited certification of x-ray technicians should be suspended in view of the advice from the Association of Medical Specialty Societies that there is no agreement among the societies on this issue, and that the Department of Environmental Protection and the X-ray Technician Certification Board would not be in

favor of this approach.

Note: At the September 21, 1980 meeting of the Board of Trustees it was agreed to support broadening the scope of the limited certification of x-ray technicians through the introduction of legislation and our Council on Legislation was in favor of pursuing this.

Nurse/Midwife Regulations ... Noted that in the matter of challenging the nurse-midwife regulations of the State Board of Medical Examiners, Mr. Maressa will meet with representatives of the specialty groups involved to discuss the difficulties he foresees with such litigation.

Medical Fee Collection System ... Voted to endorse a program offered by I.C. Systems, Inc., for the collection of medical fees. Under this system the Society would underwrite the cost of distribution and marketing; however, these expenses would be recovered under the contract arrangements with I.C. Systems, Inc.

Vector-Borne Diseases ... Approved a recommendation that MSNJ participate, with a contribution of \$100, in co-sponsoring (with the New Jersey Public Health Association) a symposium on vector-borne diseases to be presented on April 8 in New Brunswick.

MSNJ Charter Change ... Noted that Senate Bill 1390 (MSNJ charter change legislation) had passed the Senate by a vote of 31 to 0 and will go to the Assembly early this year.

Board of Managers of Jersey City Medical Center ... Voted to endorse Barry A. Maltzman, M.D., for appointment by the Governor to the Board of Managers of the Jersey City Medical Center.

CMDNJ Report ... Received as informative a report from Stanley S. Bergen, Jr., M.D., President of the College of Medicine and Dentistry of New Jersey, which called attention, among other things, to the following:

1. Recommendations concerning family practice:

(a) That the school maintain an open mind on the possibility of establishing a family practice department; and

(b) That the school and its faculty continue positive support of family practice as a specialty and as a partial solution to the primary care needs in New Jersey.

2. Foreign Medical Schools:

The Board of the Department of Higher Education will challenge a formal opinion recently issued by the Attorney General which gives control over seventh and eighth semester education programs for foreign medical school students to the State Board of Medical Examiners.

Medical/Legal Seminar, MSNJSA ... Noted that a medical/legal seminar presented to medical students by the Department of Liability Control at MSNJ headquarters on November 14, 1980 had been well received by the students and it is planned to conduct similar programs for MSNJSA in the future.

JEMPAC ... Received as informative a report on JEMPAC activities for the period February 1980 through December 1980.

Health Care Administration Board ... Received as informative a report from Daniel J. O'Regan, M.D., on his attendance at the December 4, 1980 meeting of the Health Care Administration Board.

AMA Interim Meeting, December 7-10, 1980 ... Received a report from William J. D'Elia, M.D., chairman of the New Jersey AMA Delegation which called attention to the following actions of the AMA House of Delegates:

(a) PSRO Programs

That the AMA's current policy would be to continue professionally directed efforts to ensure that care provided to patients is of high quality, appropriate duration, and is rendered in an ap-

appropriate setting at a reasonable cost, and to encourage the elimination of all government-directed peer review programs, including PSROs.

(b) Health Planning Legislation

That the AMA seek repeal of health planning legislation and set a new policy calling for the elimination of professional standards review programs, including PSROs.

(c) Physicians' Assistants

That legislation to increase public funding for programs to train physicians' assistants be opposed (as recommended in a report on physicians' assistants by the AMA Councils on Medical Service and Medical Education), and that a careful reevaluation of the need for public funding be made at the time the present legislative authority expires.

A further report of the final actions taken at the Interim Meeting of the AMA will be made later.

Ad Hoc Committee to Review Insurance Benefits for Psychiatric Care . . . Received a majority and minority report from the Ad Hoc Committee to Review Insurance Benefits for Psychiatric Care on proposed legislation to supplement N.J.S.A. 17(B):27 which has been developed to implement Resolution #20 (1979) to support the "provision of benefits for the care of emotional and mental illness under all government and private insurance programs, equivalent in scope and duration to those benefits provided for other medical or physical illness."

The proposed legislation reads as follows:

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. Every insurer which delivers or issues for delivery, renews, or modifies group health insurance contracts in this State providing hospital or medical expense benefits, shall provide to any subscriber or other person covered thereunder, subject to the insurer's standard of insurability, coverage for reasonable and necessary treatment for mental, emotional, or nervous conditions. Minimum benefits must include at least the following:

a. Basic benefits shall include inpatient treatment of 30 days per year or its equivalent of partial hospitalization of 60 days per year. Hospitalization may be at any medical facility, including those owned or operated by the state or county, accredited by the Joint Commission on Accreditation of Hospitals and capable of the diagnosis and treatment of psychiatric, mental, and nervous disorders. Partial hospitalization means continuous treatment for at least three hours but not more than twelve hours in any 24-hour period in a facility designed for such purposes.

b. Contracts which provide outpatient medical coverage for any diagnosable condition shall include benefits for patients with

mental disorders as defined in DSM-III and its subsequent revisions by the American Psychiatric Association. These services must be provided by a psychiatrist who is a licensed physician in the State of New Jersey. The insurer shall be required to pay no less than 80 percent of the treatment expenses based upon the standard of the usual and reasonable fees. An initial deductible expense may be applied by the insurer but cannot be greater than that which applies to any other medical condition. Treatment shall not be limited to less than 50 visits per year per insured.

c. No person shall disclose mental health history, diagnosis, or treatment services' information received in an initial application for coverage or subsequent claims for benefit to any person, group, organization, or governmental agency, except for purposes of obtaining professional review and judgments of quality and appropriateness of treatment rendered, or upon order of a Court for the purpose of litigation proceedings involving the insured, or when required for the purpose of claiming benefit for services on behalf of the insured, without written consent of the insured.

d. No person shall be required to report his Social Security number for purposes of obtaining coverage or, after obtaining coverage, for claiming benefits unless required by applicable Federal Statute or regulation.

2. All reimbursable providers, whether private or institutional, shall be subject to peer review by an appropriate review team.

3. This Act shall take effect immediately.

The minority report prepared by Doctors Bernstein and Morrison indicated the following problems in accepting the model bill prepared by the New Jersey Psychiatric Association:

(1) The markedly increased cost for all health insurance packages that include equal payment for emotional disease; increased cost will increase public pressure for more governmentally funded programs; increased costs for IPA/HMOs while they still are trying to become established in New Jersey could bankrupt them. (These could be exempted for five years.)

(2) The transferring costs from governmental sector to private for non-institutionalized care of chronic psychiatric and senile patients. This cost and the cost of inpatient treatment of psychiatric patients traditionally have been borne by government for centuries. If the private sector takes over the care by expansion of insurance coverage there is little hope that there will be any tax reduction to reflect this change.

(3) The degree of psychiatric illness requiring treatment is almost impossible to define. The length of treatment is ill-defined, and the proper treatment or treatments are not agreed upon. Thus, peer review is almost impossible.

The report further stated, "We sym-

pathize with the psychiatrists, but are fearful of the overall impact upon the public and the rest of the medical profession of the markedly higher premiums that inevitably will be needed to support insurance as dictated by the model bill of the New Jersey Psychiatric Association."

. . . Approved a recommendation that MSNJ encourage the inclusion of psychiatric benefits in insurance plans.

. . . Postponed consideration indefinitely of a recommendation that the Board of Trustees approve the introduction of legislation as drafted.

Note: This decision was based on additional information supplied in the report of the AMA Council on Scientific Affairs which states that the American Psychiatric Association will address the need for quality control for psychiatric therapy and has appointed a Commission on Psychiatric Therapy to examine the various therapies currently in use. The AMA will serve as the consultant organization. The Board felt that it would be premature to recommend specific guidelines for legislation before the Ad Hoc Committee can consider the future report of the Commission on its study of psychiatric therapy.

Committee on Cancer Control . . . Received as informative a report from the Committee on Cancer Control which revealed that the Committee believes its most valuable services lie in functioning as a watchdog and in making recommendations concerning activities of the State of New Jersey dealing with cancer, and as liaison with the American Cancer Society, the American College of Surgeons (particularly in their cancer registry activities), the Departments of Preventive Medicine of the New Jersey Medical School and of Rutgers Medical School, the State Department of Health and the New Jersey State Osteopathic Society.

Cardiopulmonary Resuscitation Program

. . . Approved the following recommendation from the Committee on Emergency Medical Care concerning a cardiopulmonary resuscitation program:

That the Medical Society of New Jersey adopt a policy to support cardiopulmonary resuscitation training in industry.

That the CPR Program be undertaken by all personnel in industry through a three (3)-hour cardiac defender course; and that it be recommended (this is not a mandate) that

supervisory and management personnel be trained in an eight (8)-hour CPR recertification program with annual refresher training.

That this information be published in the MSNJ *Newsletter* and monthly *Journal*; and that the New Jersey Hospital Association publish this in their bulletin.

Note: A recommendation from the Committee on Emergency Medical Care had been submitted to the Board earlier but was referred back to the Committee as the Board felt MSNJ did not have the authority to mandate to industry how its management and supervisory personnel should be trained.

Special Committee on Long Range Planning and Development . . . Voted to postpone consideration of the lengthy report dealing with MSNJ Auxiliary and the evaluation of the Medical Society by the American Society of Association Executives, prepared by the Special Committee on Long Range Planning and Development until the February 1st meeting of the Board.

Medical Defense and Insurance . . . Approved the following recommendations concerning unfair claims settlement practices—an item referred to the Committee for investigation as to whether medical facts should be withheld from claimants in explaining a claim denial:

1. That the Board of Trustees inform Robert L. Bildner, Esq., Director of the Division of Consumer Services, N.J. State Department of Insurance, with regard to the Proposed Rules on Unfair Claims Settlement Practices, N.J.A.C. 11:2-17, that the regulation should require insurance companies to inform the attending physician of a claim denial on the basis of health or the issuance of a policy different from that applied for; and that notification to the client and the attending physician should be issued at the same or similar time, pertinent medical information to be released only to the physician (for his discretion in informing the patient of such medical information).

2. That the Medical Society of New Jersey support the New Jersey State Medical Underwriters, Inc. in its efforts to have malpractice insurance carriers excluded from the Proposed Rules on Unfair Claims Settlement Practices, N.J.A.C. 11:2-17; and if this is not possible, to change the regulation requiring claims settlements within 30 days to allow a much longer time frame for professional liability carriers.

New Jersey State Medical Underwriters, Inc. . . . Approved a recommendation from the Committee on Medical Defense and Insurance that members of MSNJ be urged to obtain the maximum of professional liability insurance avail-

able to them.

Note: In the discussion of the question of the amount of liability insurance really sufficient to cover a physician, Mr. Sweetland of the New Jersey Medical Inter-Insurance Exchange explained that the Exchange cannot recommend publicly an amount because the Exchange could be held responsible for any amount over the coverage the physician purchased.

Maternity Benefits for Unmarried Dependent Children . . . Approved a recommendation from the Committee on Medical Defense and Insurance that Blue Cross/Blue Shield and Major Medical program's maternity coverage available to members of MSNJ be extended to unmarried dependent children, effective January 1, 1981.

Blue Shield Second Opinions . . . Approved as amended by the Board a recommendation from the Committee on Medical Defense and Insurance that *voluntary* second surgical opinion coverage be added to the Blue Cross/Blue Shield programs offered to MSNJ. (Italics indicate Board amendment.)

Blue Shield 500 and 14/20 Series . . . Approved a recommendation from the Committee on Medical Defense and Insurance that the Blue Shield 14/20 Series be offered to members of MSNJ and that the Blue Shield 500 Series no longer be offered to new participants, effective January 1, 1981.

Coordination of Benefits . . . Approved a recommendation from the Committee on Medical Defense and Insurance that coordination of benefits be added to MSNJ's Blue Cross/Blue Shield and Major Medical programs.

Medicaid Survey . . . Approved a recommendation from the Committee on Medicaid, as amended by the Board, that no survey of physicians treating Medicaid patients be conducted at this time in any county without the prior approval and agreement of the appropriate county medical society.

Note: The above is in response to a directive from the Board of Trustees that the Committee consider such a survey.

Medicaid Reimbursement . . . Approved a recommendation from the Committee on Medical Defense and Insurance that the Medical Society of New Jersey take appropriate steps to introduce legislation to include a provision in the New

Jersey Medicaid law for physicians' fees to be upgraded annually in the same manner as nursing homes and hospitals.

Professional Liability Update . . . Received a report from Dr. James S. Todd, chairman of the board of directors and Mr. Peter Sweetland, president of the New Jersey State Medical Underwriters, Inc., abstracted below.

Dr. Todd—The problems of professional liability and its insurance seem to be growing. The National Association of Insurance Commissioners' long-term report involving 72,000 claims contains little to garner optimism—as to professional liability across the country, despite the fact that there are many physician-owned companies. During the period of this report, 1975 to 1978, the average award jumped from \$26,700 to \$45,200, an increase of 69 percent, and the cost of contesting the claims increased even more—73 percent. Doctors in California and New York continue to be those most likely to be sued; Arkansas and North Dakota doctors are least likely to be sued. The specialties leading in losses throughout the country continue to be anesthesiology, neurosurgery and obstetrics, and this parallels the experience in New Jersey. More than a third of suits filed are because procedures are done improperly. Diagnostic errors account for 27 percent and drug injuries about ten percent. The size of awards is increasing rapidly. Million dollar plus awards represent three out of every 1,000 claims. In 1975 the ratio was one of 1,000. A continuing problem is that a premium is set for exposure in a given year but the claim may not be paid for three years; considering the rate of inflation, what is happening is obvious. The national picture is deteriorating and there are some who predict a return to the crisis of 1975.

Concerning the position of the New Jersey State Medical Underwriters and the Medical Inter-Insurance Exchange of New Jersey, it has been established since the inception of the company that things will be done differently. It is hoped to find a different solution to the professional liability crisis. The Exchange has control of dollars and cents and is operating efficiently. In spite of this, an increase in professional liability rates is being asked. Some significant inroads have been made into the traditional method of handling malpractice insurance; however, we still are dependent upon the experience of prior carriers. Our data are not mature enough to go on our own. We have a responsibility

to our insureds (until such time as we have adequate and definite indications that we are doing things differently) to act as an innovative insurance company but to reserve as a traditional commercial carrier so that if we should be wrong in our projections we suddenly will not have to increase our premium requests greatly. If it is found over the years that too much has been charged, rest assured the money is yours. There is no profit motivation. The Exchange has a strong staff, a strong underwriting policy and the most innovative approach to the problem. If there is a solution, it will be found in New Jersey, but we do not want to make either political or other decisions that will cause trouble in the future.

Mr. Sweetland—In explaining how the rate was determined, it was pointed out that the assistance of an independent actuary was sought to review past loss data in New Jersey, which in terms of analysis goes back for a period of ten years. The Exchange is proud of the areas of improvement in the normal conduct of an insurance business and a number of these features are set forth in the professional liability commentary which appears monthly in *The Journal*, MSNJ. It is apparent that money is being saved in the handling of claims that are paid, that operation expenses are at a lower ratio than the average firm, and insured physicians have been encouraged to report cases promptly. Despite this, the average value of a paid loss in New Jersey is going up. The frequency of cases per insured physician is going up, and the ability to control these two factors is obviously the critical element in managing medical liability insurance. In terms of dollars of value, the average value of a closed claim for 1977 appears to be \$32,827. The projection for 1981 is \$40,699. The actuary initially recommended a rate increase in excess of 30 percent. Methods of operation were reviewed and the final recommendation from the actuary was for an increase of 15.7 percent. This was further reduced through removal of a contingency factor and an adjustment of the expense ratio, and approval has been given to filing a rate increase of 9.7 percent. The State Reinsurance Authority has filed for an increase of 28 percent. A yearly review of past loss experience by specialty and relativity classes is made and the actuary's recommendation is that the differentials set up a year ago still were appropriate; changes in classification made over the last two years continue to be borne out. Renewal ques-

tionnaires recently were mailed to insureds and the response has been excellent. One issue that continues to surface is that income from investments has exceeded loss paid out. This was expected; however the average monthly payout in loss dollars is expected to exceed investment income. The issue is a philosophical one—if you know you have a liability or your best technical advice tells you that you have a potential liability, these losses will come about. It is the opinion of the leadership of the Exchange that rates must be made in a way to fund for that liability and not to defer it simply because for the time being there is income from investment that keeps you afloat. This cash flow method has caused a number of companies to suffer in the past and the Board of Governors believes it would be imprudent to ignore the best technical projection of future losses.

Reinstatement Policy for Dues Delinquent Members . . . Voted to reaffirm its approval of the proposed reinstatement policy and agreed that a recommendation to refer it to the House of Delegates for consideration was appropriate.

Note: Essex County Medical Society is opposed to the proposed \$50 penalty on dues delinquent members and requested the Board to reconsider its decision to approve this policy and its action to refer it to the House of Delegates for consideration.

Rubella Screening . . . Requested that the Committee on Maternal and Child Care report to the Board at its February 1st meeting on the regulation (N.J.A.C. 8:31-26.3) requiring all persons employed in clinics and/or medical practices caring for pregnant women to be immunized against rubella.

Proposed Excessive Fee Regulation . . . Accepted the following resolution from the Bergen County Medical Society concerning the Board of Medical Examiners:

RESOLVED, that the Bergen County Medical Society is unalterably opposed to the proposals on excessive fees as presented by the Board of Medical Examiners of the State of New Jersey; and be it further

RESOLVED, that a copy of this Resolution be presented to the Medical Society of New Jersey, as well as the various component county societies.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Ramesh M. Nayak, M.D., 800 Sawyer Hall, 2910 Scioto Street, Cincinnati, OH 45219. Seth G.S. Medical (India) 1971. Board eligible. Solo, small group. Available.

Won S. Cho, M.D., 1303 Midmeadow Road, Towson, MD 21204. Korea University, 1963. Board eligible. Group, partnership, or solo. Available on one month's notice.

CARDIOLOGY—Lawrence J. Gessman, M.D., 21 Sabine Avenue, Narberth, PA 19072. University of Pennsylvania 1974. Board certified. Group, partnership (preferably with cardiac catheterization). Available.

GASTROENTEROLOGY—Jacques M. Schmid, M.D., 225-F Edgemoor Road, Bridgeport, CT 06606. Einstein 1976. Also general internal medicine. Board certified (IM). Any type practice. Available July 1981.

George J. Rezk, M.D., 7713 Fort Hamilton Parkway, Brooklyn, NY 11228. Bologna (Italy) 1976. Board eligible. Group or partnership. Available July 1981.

GENERAL PRACTICE—Carlos A. Viola, M.D., Avenida Cordoba 77 Oeste, San Juan 5400, Argentina, South America National University, Buenos Aires 1950. Also, general surgery. Institutional, group, or partnership. Available.

Kirit J. Shah, M.D., 136 Thornhill Road, Cherry Hill, NJ 08003. S.S. Medical (India) 1970. Group or solo in community in need of a physician. Available.

HEMATOLOGY/ONCOLOGY—Frank Gentile, M.D., 654 Dahill Road, Brooklyn, NY 11218. Bologna (Italy) 1972. Board eligible. Solo, group, associate, partner. Available July 1981.

INFECTIOUS DISEASES—David Brooks, M.D., P.O. Box 33172, San Diego, CA 92103. Dublin (Ireland) 1962. Also general internal medicine. Available.

INTERNAL MEDICINE—David J. Stone, M.D., 105 Stewart Circle, Charlottesville, VA 22903. NYU 1974. Board eligible. Group. Available July 1981.

Howard Allen Sackel, M.D., 39 Cottonwood Drive, Stoughton, MA 02072. SUNY-Upstate 1976. Subspecialty, nephrology. Board certified. Group or partnership. Available July 1981.

Sharon D. Warner, M.D., 115 Old Short Hills Road, Apt. 274, West Orange, NJ 07052. SUNY-Downstate 1978. Board eligible. Partnership, single or multi-specialty group. Available July 1981.

**Alert and
functioning
in the
sunset
years**



Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule
contains:

Pentylenetetrazole 100 mg
Nicotinic Acid 100 mg
Ascorbic Acid 100 mg
Thiamine HCL 25 mg
L-Glutamic Acid 50 mg
Niacinamide 5 mg
Riboflavin 2 mg
Pyridoxine HCL 3 mg

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Martin Lerman, M.D., 3258 Lauriston Place, Fairfax, Virginia 22030. Georgetown 1973. Board certified. Any type practice. Available.

Fayez A. Roumani, M.D., P.O. 522, Bradford, PA 16701. Damascus (Syria) 1973. Subspecialty, nephrology. Board eligible. Group or hospital-based. Available.

Steven Rosner, M.D., 150 Colton St., Apt. 3-D, Staten Island, NY 10305. New York Medical College 1976. Subspecialty, rheumatology. Board certified. Group, partnership. Available July 1981.

Robert J. Moran, M.D., 801 East 10th Street, Brooklyn, NY 11230. SUNY-Downstate 1977. Board eligible. Group, partnership, or hospital-based. Available July 1981.

Joseph A. Catapano, M.D., 298 Townhouse, Hershey, PA 17033. Rutgers 1976. Also, clinical cardiology. Board certified. Available July 1981.

Modhi Gude, M.D., 210 Shippen Street, Weehawken, NJ 07087. Andhra Medical (India) 1968. Subspecialty endocrinology. Board certified. Group, partnership, or solo. Available July 1, 1981.

Maria Del Rosario Gomez, M.D., 294 Thunder Circle, Bensalem, PA 19020. Madrid 1976. Board eligible. Group or partnership. Available July 1981.

NEPHROLOGY—Krishnababu Chunduri, M.D., 2121 Shore Parkway, Apt. 2-F, Brooklyn, NY 11214. Guntur (India) 1973. Board eligible. Solo or group. Available.

Vijay K. Nellore, M.D., 134 North Street, Bayonne, NJ 07002. Osmania (India) 1973. Solo, group, or institutional. Available July 1981.

NEUROLOGY—Alan J. Friedman, M.D., 114 Adena Road, West Newton, MA 02165. Cornell 1974. Board certified (IM). Board eligible. Group or partnership. Available July 1981.

OBSTETRICS/GYNECOLOGY—Gary S. Rosenberg, M.D., 245-20 Grand Central Parkway, Bellerose, NY 11426. SUNY-Downstate 1977. Solo, group, partnership. Available July 1981.

Shreedhar P. Abhyankar, M.D., 15-J Sycamore Drive, Norwalk, OH 44857. B.J. Medical (India) 1971. Board eligible. Solo, partnership, group, (small or medium-sized town). Available.

Kailash R. Makhija, M.D., 5628 Fifth Avenue, Apt. B-10, Pittsburgh, PA 15232. GMC (Bombay, India) 1974. Board eligible. Group, partnership, solo, with coverage, suburban area. Available July 1981.

ONCOLOGY—D. S. Prajapati, M.D., 88 Slate Creek Drive, #5, Cheektowaga (Buffalo) NY 14227. Baroda (India) 1972. Board certified. Group, partnership, solo. Available July 1981.

Steven E. Zimmerman, M.D., 7562 Westlake Terrace, Bethesda, MD 20034. Cornell 1976. Also, general internal medicine. Board certified (IM). Group or partnership preferred, also solo. Available July 1981.

OTOLARYNGOLOGY—Howard Taylor, M.D., 8201 Henry Avenue, Apt. P-3, Phila-

delphia, PA 19128. Columbia 1972. Board eligible. Partnership, group. Available July 1981.

PATHOLOGY—Kaushik J. Pandya, M.D., 30-49 70th Street, Jackson Heights, NY 11370. Baroda (India) 1974. Any type practice. Available July 1981.

Maneala V. Betkerur, M.D., 10015 S. Hill Terrace 28/202, Palos Hill, IL 60465. Karnatak (India) 1974. Subspecialty, neonatology. Board certified. Group, institutional. Available July 1981.

Aiyam P. Sivaramakrishnan, M.D., 3520 Keystone Avenue, #3, Los Angeles, CA 90034. Seth G. S. Medical (India) 1971. Subspecialty, pediatric cardiology. Board certified. Group, institutional, hospital-based, HMO. Available.

Sitamahalakshmi Nutakki, M.D., 22 Metropolitan Oval, #5G, Bronx, NY 10462. Guntur (India) 1970. Board eligible. Group or partnership. Available.

Meera V. Bodas, M.D., 4 Manitou Way, Scotch Plains, NJ 07076. Nagpur Medical (India) 1967. Board eligible (AP/CP). Group (part-time also acceptable). Available July 1981.

Shokat Fattgh, M.D., 260 First Street, Mineola, NY 11501. Baroda (India) 1975. Board certified. Any type practice. Available May 1981.

PEDIATRICS—Anil G. Pradhan, M.D., 118 Grove Park, Fort Dix, NJ 08640. Bombay (India) 1972. Board certified. Solo, partnership, associate, group. Available.

Rajendra C. Parikh, M.D., 77-07 Woodside Avenue, Apt. 3-A, Elmhurst, NY 11373. Baroda (India) 1975. Board eligible. Group, partnership, solo, or institutional. Available June 1981.

Shara J. Doshi, M.D., 304 Fir Street, Raceland, Louisiana 70394. B.J. Medical (India) 1969. Board eligible. Solo, group, partnership, clinic. Available.

PSYCHIATRY—Florence Ouseph, M.D., 2200 South Rock Road, Apt. 1108, Wichita, Kansas 67207. Christian Medical (Vellore, India) 1975. Board eligible. Institution (VA Medical Center). Available November 1981.

RADIOLOGY—U. Chaibongsai, M.D., 992 Woodmere Drive, Westfield, NJ 07090. Siriraj (Thailand) 1968. Board certified. Part-time, group, partnership. Available.

Indu M. Solanki, M.D., 266 Beaufort Avenue, Livingston, NJ 07039. B.J. Medical (India) 1967. Board certified. Solo, group, or partnership. Available.

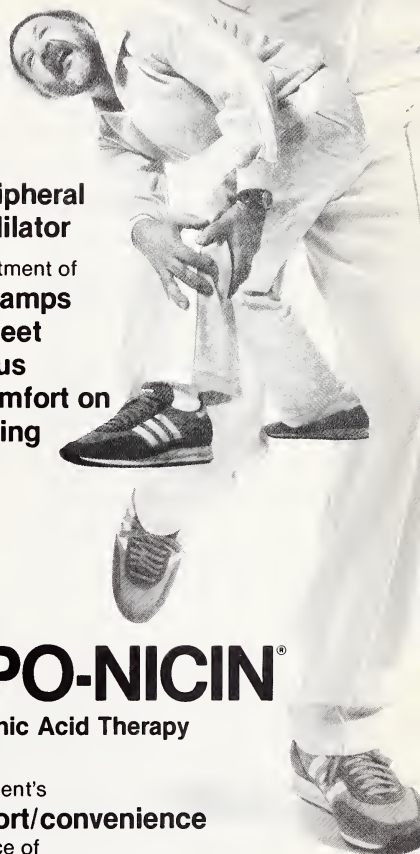
Sita V. Krishnaswamy, M.D., 1735 Haight Avenue, Bronx, NY 10461. Grant Medical College (India) 1972. Emphasis on therapeutic radiology. Board eligible. Any type independent practice or partnership. Available July 1981.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379. Shah (India) 1969. General practice and rehabilitation medicine. Available on three months' notice.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on
standing



LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	300 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	250 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	100 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available July 1981.

Thomas A. Giangrosso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available July 1981.

SURGERY, GENERAL—Zahur U. Azhar, M.D., 1684 Central Avenue, Bridgeport, CT 06610. Nishtar (Pakistan) 1963. Board eligible. Solo. Available July 1981.

Dariusz Vaziri, M.D., 7510 Brompton Court, Apt. 587, Houston, TX. Tehran (Iran) 1974. Also, vascular surgery. Board eligible. Group, partnership. Available August 1981.

Carlos A. Viola, M.D., Avenida Cordoba 77 Oeste, San Juan 5400, Argentina, South America. National University, Buenos Aires 1950. Also, general medicine. Institutional, group, or partnership. Available.

S. W. Choi, M.D., 14 Phyllis Place, Milltown, NJ 08850. Seoul (Korea) 1967. Board certified. Group or partnership. Available.

Jawaid Akhtar, M.D., 21634 Stratford Court, Oakpark, MI 48237. Karachi (Pakistan) 1967. Also, colon and rectal surgery. Board certified (general and color and rectal). Solo, group, partnership, or associate. Available.

Ruben J. Delgado, M.D., 293 First Street, Mineola NY 11501. Puerto Rico 1976. Also, vascular surgery. Board eligible. Group or partnership. Available July 1982.

Bijoy Bhushon Sarmaroy, M.D., 631 East 235th Street, New York, NY 10466. Assam Medical (India) 1968. Group, partnership, solo. Available July 1981.

Mohammad Qubair, M.D., 2694 South Hoyt Street, Lakewood, CO 80227. Pakistan 1970. Board eligible. Partnership, solo. Available July 1981.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available July 1981.

Inder J. Singh, M.D., WCMC #1-C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available July 1981.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available July 1981.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available June 1981.

UROLOGY—Elliott Lieberman, M.D., 16-66 Bell Boulevard, Apt. 730, Bayside, NY 11360. SUNY-Downstate 1976. Group or partnership. Available July 1981.

William Kohlberg, M.D., 3450-17A Wayne Avenue, Bronx, NY 10467. Pittsburgh 1975. Board eligible. Group or partnership. Available July 1981.

Paul A. Church, M.D., 435 East 70th Street, Apt. 27-C, New York, NY 10021. Cornell 1975. Board eligible. Solo, partnership, group. Available June 1981.

Vasant Betkerur, M.D., 10015 South Hill Terrace, 28/202, Palos Hill, IL 60465. Government Medical (India) 1973. Solo, partnership, group. Available July 1981.

Harvey Schoenbrum, M.D., 1249 Park Avenue, Apt. 14-A, New York, NY 10029. Pittsburgh 1976. Board eligible. Group, partnership. Available July 1981.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available June 1981.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available July 1981.

Robert D. Zimmerman, M.D., 206 Friar Lane, Clifton, NJ 07013. Chicago Rush-Presbyterian. Board eligible. Partnership, solo, group. Available July 1981.

Cardiopulmonary Resuscitation Program for Industry

The following recommendation was adopted by the Board of Trustees on December 21, 1980 (see page 223, this issue) and is here recorded in accordance with the dictates of the Board:

That the Medical Society of New Jersey adopt a policy to support cardiopulmonary resuscitation training in industry. That the CPR Program be undertaken by all personnel in industry through a three-hour cardiac defender course; and that it be recommended (this is not a mandate) that supervisory and management personnel be trained in an eight-hour CPR recertification program with annual refresher training.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

As CMDNJ-College Hospital enters only its third year of operation, this Newark health care facility is continuing to offer innovative programs that are unique in New Jersey, and therefore should be of interest to physicians throughout the State. The programs embrace the sociological and psychological

aspects of treatment, as well as the medical.

ABUSED PERSONS PROGRAM

One such project is the College Hospital Abused Persons Program (CHAPP), which was instituted recently to consider all cases of domestic violence, whether they involve children, women or men. CHAPP provides a highly unusual counseling service and referral services to residents of the Newark area.

The program aims to dispel persistent myths about domestic violence, particularly the "it-can't-happen-to-me" attitude. Clinicians point out that domestic violence can become a part of anybody's life, regardless of age, culture, socioeconomic status or religion. Counseling, both for individuals and couples affected by domestic violence, is at the core of CHAPP's services.

The five professional mental health clinicians who conduct the sessions recently completed a training program—the only one of its kind in the United States—which incorporates domestic violence theory with training in specialized clinical skills. The counselors also treat patients in the Crisis Intervention Unit of the CMDNJ-New Jersey Medical School Community Mental Health Center and operate a 24-hour telephone help-line. Under a grant from the Foundation of CMDNJ they also have prepared educational literature about domestic violence.

In addition to providing medical and surgical interventions at College Hospital, other services offered by CHAPP include referrals to various area agencies for such needs as temporary shelter, legal services, emergency funds and vocational training.

NEUROMUSCULAR DISEASES CENTER

Another new development at College Hospital, in conjunction with CMDNJ-New Jersey Medical School, was the recent founding of a Neuromuscular Diseases Center, the only such screening and treatment program in New Jersey. The new center is directed by Marinos C. Dalakas, M.D., neuromuscular diseases specialist formerly with the National Institutes of Health. Dr. Dalakas is assistant professor in the Department of Neurosciences at the Medical School and also director of a new Muscular Dystrophy Clinic at the hospital.

The center's goals are to establish clinical efforts to help patients with such diseases as myasthenia gravis, polymyositis, polyneuropathies,

muscular dystrophies, amyotrophic lateral sclerosis (Lou Gehrig's Disease), myotonias and metabolic muscle diseases. The center will employ a multidisciplinary approach, including clinical experience in handling electromyographic studies and muscle or nerve biopsy for histochemistry, biochemistry, tissue culture, immunocytochemistry and electron microscopy.

Most of the tests can be done on an outpatient basis, although some require a brief hospitalization. For a few very specialized tests, physicians at College Hospital collaborate with colleagues in other parts of the country. Fees for diagnostic tests, clinical help, genetic counseling and transportation are paid by the Muscular Dystrophy Association.

TEENAGE ALCOHOLISM

Recognizing that teenage alcoholism is a national problem, College Hospital's Alcoholic Treatment Center recently has established a Counseling-in-Action program as a peer group counseling service for these adolescents, as well as drug abusers, and their families.

It has been estimated that there are more than 12,000 known alcohol abusers between the ages of 14 and 17 in Essex County alone, but directors of the counseling program believe there are probably many more who never have been identified by the courts or school authorities. Statistics also indicate that of the 70 percent of American high school students who experiment with alcohol, as many as half may be abusers. Because substance abuse often accompanies alcohol abuse, the program is amassing mounting evidence of dual addiction among teenagers.

The concept of peer counseling for adolescent abusers was developed because peer approval is one of the most significant determinates of adolescent behavior. Every teenager who comes to the Alcoholic Treatment Center for treatment is evaluated by a social worker, and those who do not require more intensive therapy are referred to the counseling program. Counselors, who have received the same training that is provided by the center to professional alcoholism counselors, advise not only their peers but the parents and siblings of adolescent alcohol abusers as well. Counseling sessions, which are free of charge and confidential, are conducted at the center every Monday, Wednesday and Thursday afternoon.

To facilitate wide utilization of the program's services, Newark area school

counselors will refer teens in need of therapy to the program. In addition, a diagnostic check list, to be used by judges, lawyers and probation officers to identify adolescent alcohol abusers, has been developed and disseminated, and a videotape for professional alcoholism counselors that dramatize techniques also has been produced.

Other services provided by the Alcohol Treatment Center include individual and group psychotherapy for adults, marriage and family therapy, medical assessments and treatment, nutritional counseling and vocational assistance. The center also sponsors an Alcoholics Anonymous group as well as daily, alcohol-free recreational activities for members of its alumni association and their families and friends.

AMA VIDEO CLINIC

The typical American physician has much to do and never enough time. This question of how to acquire the continuing medical education you want or need has concerned many physicians. More and more states (19 now) require CME for medical-license reregistration, 20 medical societies require it for continued membership.

The AMA offers a way—the AMA Video Clinics, a well-rounded selection of approved courses in the form of color videotapes, self-assessment tests and illustrated study guides.

The benefits of such a program include:

- *Convenience*—No need for long, expensive out-of-town journeys, no disruption of your practice. Alone or with colleagues, you can use the Video Clinics in the office, hospital, living room or den.
- *Succinctness—With Depth*—The Clinics are two to six-hour courses encompassing the physiology, etiology, diagnosis, treatment and prognosis in a disease area.
- *Authoritativeness*—Each Video Clinic was developed by the AMA Council on Continuing Physician Education in cooperation with leading medical schools and top-authority MD's.
- *Accreditation Credits*—On an hour-for-hour basis the AMA Council on Continuing Physician Education is a CME-accrediting body.
- *Breadth of Choice*—Subjects available are:

Backache, Vulvovaginal Problems, Practical Rheumatology, the Comatose Patient, the Multiply Traumatized Patient, Neurological Examination, Dizziness, Headache, New Pain, Hypertension, Acute Gastrointestinal Bleeding, Antibiotic Therapy in Office Practice, the Depressed Patient, Bronchial Asthma, Alcoholism: Early Diagnosis and Management

- *Permanence*—You can shelve these study guides in your medical library for followup viewing.
- *Inexpensiveness*—Compare the cost of AMA Video Clinic to that of attending an out-of-town meeting.
- *Easy Availability*—You can rent or purchase any or all of the 15 Clinic programs by writing or calling the Department of Marketing Communications, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, (312) 751-5951.

Report from the Foundation
Daniel J. O'Regan, M.D.
Medical Director

Once again, we are awaiting indications from a new administration on its attitude toward the "health care industry." The desire for reduction in all kinds of federal regulations was expressed many times during the campaign. This has led some of our colleagues to expect wholesale elimination of intrusions on medical practice. While there will be changes in methods and mechanisms, the attempt to slow down the cost of medical care will go on.

The *Star-Ledger* reported, on January 22, 1981, that President Reagan had accepted the resignations of the 15 inspectors general in the executive branch. They will be replaced, according to Press Secretary James Brady by others who will be "meaner than a junkyard dog" in rooting out waste and fraud.

Secretary Schweiker of HHS has met with the new Comptroller General, Elmer Staats, to discuss ways to cut fraud, abuse and waste. The Secretary promised to strengthen the Inspector General's office in his department. Public Law 95-142, as you recall, gave power to the Inspector General to deal with fraud and abuse in Medicare and Medicaid.

Senator Dole, Chairman of the Senate Finance Committee, has indicated that elimination of fraud and abuse is necessary, although it may be difficult to accomplish. He favors passage of a catastrophic illness insurance plan. He is also for more competition in health. He would like to reduce the entitlement programs which tie up 94 percent of HHS' budget. This requires Congressional action. He favors less federal intervention and more funds to the states in the form of block grants. This would tend to lessen federal intervention, but could well increase state regulations.

Senator Durenberger of Minnesota is now Chairman of the Health Subcommittee of the Senate Finance Committee. He has favored the voucher system of consumer choice health plans, as suggested by Professor Alain Enthoven of Stanford. Another new leader for such a pro-competitive stance is Richard Stockman, the new Chief of the Office of Management and Budget. He already has started to work on reducing costs. The latest edition of the Gesphardt-Stockman National Health Care Reform Act was filed shortly before he went to OMB. Mr. Stockman favors removing both the PSRO and the health-planning laws. This does not mean that he will have no interest in

controlling medical costs.

Federal Trade Commission representatives have said that regulations in health care will not go away because a few committee chairmen changed. It is "naive" to think that much of the regulatory effort will be left to the profession. It has been mentioned here previously that Clark Havinghurst, the Duke law professor who advises FTC on its anti-medical association matters, is an advisor to the President.

Business and industry will spend \$63 billion on health insurance programs this year, or about one third of the nation's expenditures on health. As purchasers of care, they want to know where the dollars are going. The labor unions who bargain with the employer on the benefits in their contracts also are interested in the use of the funds.

The Bureau of Labor Statistics reported that medical costs rose 9.6 percent in 1981, the sharpest increase since 1976. This, of course, was behind the overall rise of 12.4 percent in all costs, but the increase in the rate was considered significant.

We will have to await further developments. The names mentioned above have been interested in health care matters previously and they will make their concerns more clear in the new administration. Regulations on health and medi-

cine will change, but they will not disappear. The need to keep informed and to make known the position of medicine will likewise not abate. The voluntary effort should continue, and should be strengthened. We will help to keep you informed on developments as they arise.

Dr. Thomas Almy¹ of Dartmouth Medical School described an interesting approach to medical care costs. Writing in the *New England Journal of Medicine*, he describes the technology-oriented incentives built into most payment schedules. Technical services—laboratory procedures, injections, endoscopy and others are worth more in terms of payment than are counseling, advising, listening and observing. This "piecemeal" approach mitigates against the primary physician and induces him to provide the technical services which are rewarded. Dr. Almy suggests a change in the ratio of payment for "technical" to nontechnical services. This approach is of interest, since it identifies some of the reasons for the use of ancillary services. His suggestions may not be the answer, but his awareness of the costs and true value of various services deserves repetition.

¹Almy, TP: The role of the primary physician in the health-care "industry." *N Engl J Med* 304: 225-228, 1980.

LETTERS TO THE JOURNAL

More on Nuclear Conflict

December 19, 1980

Dear, Dr. Krosnick:

Your son, Jon, was kind enough to let me see the issue (77:710-711, (Nov) 1980) of *The Journal* with your editorial on nuclear war, and the letter sent to President Carter and Chairman Brezhnev. It is reassuring to see so many in our profession speaking out on this question. Your editorial is very effective.

I am sending you a copy of a resolution which was presented to the recent AMA meeting in San Francisco. The

House of Delegates has, as I understand it, referred it to the Trustees for further study. I am sure that your views would be influential toward enlisting the AMA in this effort we both support.

I also enclose, in case you might have missed it, my own editorial in the JAMA of November 21st.

Let us hope that our efforts will meet with success, and that there will be a reconsideration of our dependence upon nuclear arms for defense.

(signed) Howard H. Hiatt, M.D., Dean
Harvard School of Public Health

American Medical Association
House of Delegates

Resolution: 3
(1-80)
Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont Delegations
Subject: Physician Responsibility in the Education of the Public on the effects of Thermonuclear Warfare
Referred to: Reference Committee H
(Clair C. Conard, M.D., Chairman)

Whereas, The human and health costs of thermonuclear warfare are of incalculable and unbearable potential severity; and

Whereas, There is growing instability of international relationships which raises anxiety that such a holocaust might conceivably occur; and

Whereas, Some physician groups have initiated leadership to support public educational programs which will alert the world to their danger; and

Whereas, The Board of Trustees of the American Medical Association has begun to study the role of physicians in this area of citizen responsibility; therefore be it

RESOLVED, That the House of Delegates commends the AMA Board of Trustees for its attention to the urgent matter of the civic responsibility of physicians in public education on thermonuclear warfare and expresses its support for the immediate education of all physicians concerning the catastrophic consequences of thermonuclear warfare.

Reprinted from JAMA 244:2314-2315, (Nov. 21) 1980

Preventing the Last Epidemic

A 20-year-old man was recently hospitalized in the burn unit of one of Boston's teaching hospitals after an automobile accident in which the gasoline tank exploded, resulting in extensive third-degree burns. During his hospitalization, he received 281 units of fresh-frozen plasma, 147 units of fresh-frozen RBCs, 37 units of platelets, and 36 units of albumin. He underwent six operative procedures, during which wounds involving 85 percent of his body surface were closed with homograft, cadaver allograft, and artificial skin. Throughout his hospitalization, he required mechanical ventilation and monitoring with central venous lines, arterial lines, and an intermittent pulmonary artery line. Despite these heroic measures, which stretched the resources of one of the country's most comprehensive medical institutions, he died on his 33rd hospital day. His injuries were likened by the person who supervised his care to those described for many of the victims of the atomic bomb that exploded over Hiroshima (J.F. Burke, MD, written communication, July 28, 1980).

Recent talk by public figures about our winning or even surviving a nuclear war must reflect a widespread failure to appreciate a medical reality: any nuclear war would inevitably cause death, disease, and suffering of epidemic proportions and without effective medical interventions. That reality, in turn, leads to the same conclusion we have reached for such contemporary epidemics as lung cancer and heart disease: preven-

tion is essential for effective control.

In contrast to widespread belief, much can be said about the catastrophe that would follow the use of nuclear weapons. Much can also be said about the limitations of existing methods of medical intervention. Perhaps so little is said about the catastrophe because it is horrible to contemplate. Surely, so little is said about intervention because so little that is hopeful can be said. If the medical community breaks the virtual silence on this issue, we might help interrupt the nuclear arms race. This, in turn, might help prevent what could otherwise be the last epidemic our civilization will know.

The devastation wrought by an atomic weapon on Hiroshima provides, along with the similar experience in Nagasaki, direct evidence of the consequences of nuclear warfare, but there are many theoretical appraisals on which we may also draw. For example, in response to a request from the Senate Committee on Foreign Relations, the Office of Technology Assessment (OTA) of the Congress of the United States, with the assistance of the Congressional Research Service, the Department of Defense, the Arms Control and Disarmament Agency, and the Central Intelligence Agency, last year prepared a study that described the effects nuclear attacks would have on Detroit and on Leningrad.¹ A 1-million-ton atomic weapon (the Hiroshima bomb approximated 10,000 tons of explosive power) exploded in central Detroit would result in 70 sq. mi. of property destruction, 250,000 fatalities, 500,000 injuries, and damage from widespread fires. A large fraction of the injuries would result from burns and others from blast and from radiation.

Even under optimal conditions, care of the injured would present a medical task of unprecedented magnitude. Since hospitals, physicians, and nurses are concentrated close to the center of the city, the OTA projected that of the 18,000 beds in and around Detroit, no more than 5,000 would remain relatively undamaged. These would accommodate only one percent of the injured, and no one could deliver the services required by the burned victim previously described.

The hopelessness of the task that would confront the surviving physician is described by John Hersey in his book, *Hiroshima*.²

Dr. Sasaki worked without method, taking those who were nearest to him first, and he noticed soon that the corridor seemed to be

getting more and more crowded. Mixed in with the abrasions and lacerations which most people in the hospital had suffered, he began to find dreadful burns. He realized then that casualties were pouring in from outdoors. There were so many that he began to pass up the lightly wounded; he decided that all he could hope to do was to stop people from bleeding to death. Before long, patients lay and crouched on the floors of the wards and the laboratories and all other rooms, and in the corridors, and on the stairs, and in the front hall, and under the porte cochere, and on the stone front steps, and in the driveway and courtyard, and for blocks each way in the streets outside. Wounded people supported maimed people; disfigured families leaned together. Many people were vomiting. A tremendous number of school-girls—some of those who had been taken from their classrooms to work outdoors clearing fire lanes—crept into the hospital. The people in the suffocating crowd inside the hospital wept and cried, for Dr. Sasaki to hear, "Sensei! Doctor!" and the less seriously wounded came and pulled at his sleeve and begged him to go to the aid of the worse wounded. Tugged here and there in his stocking feet, bewildered by the numbers, staggered by so much raw flesh, Dr. Sasaki lost all sense of profession and stopped working as a skillful surgeon and a sympathetic man; he became an automaton, mechanically wiping, daubing, winding, wiping, daubing, winding.

The surviving Detroit (and Leningrad) physicians would be faced with large numbers of patients with blast injuries, including lacerations of soft tissues and fractures; thermal injuries, including surface burns, retinal burns, and respiratory tract damage; and radiation injuries, including acute radiation syndrome and delayed effects. Infectious diseases would be rampant because of lowered resistance and widespread contamination. Severe psychological problems would be widespread.

An objective examination of the medical situation following a nuclear war leads to but one conclusion: prevention is our only recourse. The consequences of nuclear war are not, of course, only medical in nature. But they do compel us to pay heed to the inescapable lesson of contemporary medicine: where treatment of a given disease is ineffective or where costs are insupportable, attention must be given to prevention. Both conditions apply to the effects of nuclear war—treatment programs would be virtually useless and the costs would be staggering. Can any stronger argument be marshalled for a preventive strategy?

Prevention of any disease requires an effective prescription. We recognize that

¹The Effects of Nuclear War. US Office of Technology Assessment, publication #052-003-00668-5, 1979.

²Hersey J. *Hiroshima*. New York, Alfred A. Knopf Inc, 1946.

such a prescription must not only prevent nuclear war but also safeguard our security. Our knowledge and credentials as physicians do not, of course, permit us to discuss security issues with expertise. However, if our political and military leaders have based strategic planning on mistaken assumptions concerning the medical aspects of a nuclear war, we do have a responsibility. We must inform them and the American people of the full-blown clinical picture that would follow a nuclear attack and the impotence of the medical community to offer a meaningful response. If we remain silent, we risk betraying ourselves and our nation.

Howard H. Hiatt, MD
Harvard School of Public Health

Tuberculosis Classification and Treatment

December 29, 1980

Dear Dr. Krosnick:

An erroneous statement appeared (on page 913 of the December 1980 Journal) in Dr. Richard Rapkin's review of two articles on tuberculosis.

The review states that class 2 designates "infection; no disease," and that this means "a PPD negative, well patient with a negative chest x-ray." Class 2 in fact is used to designate persons with a positive PPD reaction who show no evidence of tuberculosis disease. The 0, 1, 2, 3 classification was adopted by the American Thoracic Society in May 1974. The definitions are useful in emphasizing the important distinction between tuberculosis infection without disease and tuberculosis disease, whether past or current.

In reviewing the "Guidelines for Short-Course Chemotherapy," Dr. Rapkin refers to keeping patients under surveillance after completion of treatment. The CDC recommendation is that surveillance be maintained for 12 months, provided that the sputum culture converted to negative no more than three months after the initiation of chemotherapy. Under ideal circumstances, the patient would have nine months of chemotherapy plus a 12-month period of observation, making a total of 21 months. During the 12 months of surveillance, we recommend that sputum specimens be taken at three-month intervals for examination in an approved laboratory, by smear and culture. Routine chest x-rays are not recommended during the year of surveillance.

In regard to drug dosage, two articles (*Morb Mort Wkly Rept* 1980; 29, 183 *et seq.* and 29, 589 *et seq.*) recommend that dosages for children should not exceed 10 mg/kg of isoniazid and 15 mg/kg of rifampin. Prior to initiation of these medications, it is suggested that evaluation include hematocrit, leukocyte and platelet counts, blood urea nitrogen (BUN), and serum bilirubin.

(signed) Hugh D. Palmer, M.D.
Director, Tuberculosis Service
State Department of Health

Food Allergy

January 13, 1981

Dear Doctor Krosnick:

In the December issue (*J Med Soc NJ* 77:895-899, 1980) there is an article on food allergy by Dr. Golbert.

He makes a statement—"Negative

cutaneous tests with reliable extracts imply that the suspected food or foods may be ingested without significant risk of a systemic or other immediate reaction."

Most allergists do not do skin tests with foods because the tests are unreliable. The negative test does not rule out an acute or delayed reaction to a food. It may not be the food but the digestive products of that food which causes the symptoms.

(signed) Frank L. Rosen, M.D.

Jamaica Needs Services, Medications and Supplies

January 13, 1981

Dear Dr. Krosnick:

Jamaica, West Indies, needs all the medical assistance possible. The previous Jamaican administration's policies depleted the medical resources, doctors, drugs, nurses and hospitals from this beautiful island. Now under Mr. Edward Seaga, an American-trained scholar, Jamaica needs the voluntary help of the medical and allied professions of America.

Volunteer physicians are needed to man the various hospitals until this resourceful country once again can train her own physicians. With the help of Air Jamaica, friends of Jamaica and the Jamaican government, travel and local Jamaican lodging assistance is possible.

Physicians who are interested in volunteering their services for periods of one month or more or who can help obtain medications and hospital supplies, please contact me immediately.

(signed) Leon G. Smith, M.D.

Director, Dept. Medicine
St. Michael's Medical Center
Newark

**215th Annual Meeting
Medical Society of New Jersey
May 15-19, 1981**

**Housing Application
The Meadowlands Hilton**

Please Reserve: _____ Single _____ Double _____ Twin _____ Suite

Arrival: (date) _____ at (time) _____

Departure: (date) _____ at (time) _____

Name _____

Address _____

City _____ State _____ Zip Code _____

If double or twin name of person joining _____

Single: \$56

Twin: \$67

Double: \$67

Suite: \$150 and up

If range of rates is offered and rate requested is not available, the next available rate will be assigned. Reservations must be received no later than two (2) weeks prior to the opening date of your meeting and will be held until 6 p.m. on day of arrival unless otherwise specified.

(New Jersey Sales Tax - 5%)

Complete and mail this application to: Front Office Manager
The Meadowlands Hilton
Two Harmon Plaza
Secaucus, New Jersey 07094

RECENT PROGRESS IN CLINICAL ENDOCRINOLOGY

March 21, 1981

College of Medicine & Dentistry of New
Jersey-New Jersey Medical School,
Newark, N.J.

Category I credit offered. A.O.A. accredited. A.A.F.P. applied for.

Objective: This course is intended to aid physicians practicing general internal medicine and/or endocrinology in keeping abreast of the major recent advances in the fields of endocrinology and metabolic medicine. Adequate background will be provided for those physicians who are not currently in an academic environment.

Registration fee: \$60.

For further information please contact:

Patricia Sarles, M.S.

CMDNJ-Office of Continuing Education

100 Bergen Street

Newark, N.J.

(201) 456-4267

Academy of Medicine of New Jersey
Ad Hoc Committee on Drug and Alcohol Abuse
of the Medical
Society of New Jersey

Present A Symposium On

Physicians' Role In Drug Abuse

on

WEDNESDAY, APRIL 15, 1981

at

**CMDNJ-Rutgers Medical School
Piscataway, N.J.**

The program will include presentations by nationally prominent speakers. Topics on pitfalls in prescribing controlled substances, and the role of physician in alcoholism and drug abuse will be presented.

For Further Information Contact:

Academy of Medicine of New Jersey

Two Princess Road

Lawrenceville, NJ 08648

Phone: (609) 896-1717

Dermatology Days

JUNE 25, 26 & 27, 1981

**Carousel Hotel
Ocean City, Maryland**

Sponsored by the
Division of Dermatology
Department of Medicine
University of Maryland School of Medicine

DERMATOLOGY DAYS will be composed of two concurrent symposia. One for the practicing generalist (internist, pediatrician and family physician), the second symposium is designed to help individual dermatologists. Dermatology Days is a symposium designed to help individual practitioners become aware of some of the most effective methods of diagnosis and management of dermatological problems as well as some of the newest advances in the field of dermatology. The course will focus on the use of live patients and much of the content will be derived from discussion of the actual cases presented.

In summary, this course will provide a comprehensive up-to-date exposure to many of the problems as well as current trends involved in the diagnosis and management of dermatological problems.

For further information contact:

Program of Continuing Education
University of Maryland
School of Medicine
10 South Pine Street
Baltimore, Maryland 21201
(301) 528-3956

Summer Cruise/Conferences on Legal-Medical Issues



APPROVED FOR
23 CME CREDITS
CATEGORY I

By the American College of Legal Medicine
Seminars Directed by Irwin N. Perr, M.D., J.D.
Professor, Rutgers Medical School

Caribbean Conference — July 29 — August 8, 1981 aboard
TSS Fairwind.* Visit St. Maarten, Antigua, Barbados,
Martinique and St. Thomas.

Mediterranean Conference — August 22 — September 5,
1981 aboard Mts. Danae.* Visit major cities in Italy,
Greece, Egypt, Israel, Turkey, Yugoslavia.

- All meals on cruise and aloft.
- Seminars conducted at sea.
- Alitalia scheduled flights to Italy.
- Excellent Fly/Cruise group rates.
- Hotel Danieli — Venice, Italy
- All transfers

The number of participants in each Conference is limited.
Early registration is advised.

For color brochure
and additional
information contact:

International Conferences
189 Lodge Avenue
Huntington Station, N.Y. 11746
Phone (516) 549-0869

Both conferences are designed to conform with the 1976 Tax Reform Act.

*Liberian Registry
**Greek Registry

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Apr.

- 8 **Electrical Safety**
8-9:30 p.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

May

- 13 **Metabolism of Anesthetic Agents**
8-9:30 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

CARDIOLOGY

Apr.

- 1 **Therapy in the Coronary Care Unit**
8 **Electrophysiological Approach to the Ventricular Tachycardia**
15 **Percutaneous Coronary Angioplasty**
9 a.m.-12 noon—St. Michael's Medical Center, Newark
(*St. Michael's Medical Center and AMNJ*)
8 **Cardiology Conferences**
22 3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(*Rutgers Medical School, Somerset County Heart Association and AMNJ*)
8 **Recent Advances in Cardiac Surgery**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
16 **Nuclear Cardiology**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
29- **Advanced Cardiac Life Support**
30 9 a.m.-5 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
29 **Permanent Cardiac Pacing**
9 a.m.-12 noon—St. Michael's Medical Center, Newark
(*St. Michael's Medical Center and AMNJ*)
29- **Advanced Cardiac Life Support Course**
30 9 a.m.-5 p.m.—NJ Medical School, Newark—(*CMDNJ and AMNJ*)

May

- 13 **Cardiology Conferences**
27 3:30-5:30 p.m.—Middlesex General

Hospital, New Brunswick
(*CMDNJ, Somerset County Heart Association and AMNJ*)

- 15 **Cardiac Rehabilitation**
12 noon—Freehold Area Hospital
(*AMNJ*)
16- **Advanced Echocardiography**
17 9 a.m.-5 p.m.—Nassau Inn, Princeton
(*National Foundation for Non-Invasive Diagnostics and AMNJ*)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Apr.

- 1 **Topic to be announced**
2 p.m.—St. Elizabeth Hospital, Elizabeth
(*NJ Society for Gastrointestinal Endoscopy and AMNJ*)
1 **Speech and Hearing Seminar**
8 a.m.-3:30 p.m.—J.F. Kennedy Medical Center, Edison
(*J.F. Kennedy Medical Center, Robert Wood Johnson Rehabilitation Institute and AMNJ*)
1 **Allergy**
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)
1 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section, AMNJ*)
1 **Medical Grand Rounds**
11:30 a.m.-1:00 p.m.—VA Medical Center, East Orange
(*Endocrinology Section, AMNJ*)
1 **Anemia**
9-11 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
1 **Use of Antibiotics in the Elderly**
15 **Contemporary Use of Anticoagulants**
29 **Carbon monoxide-Impact of Auto Emissions**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
1 **Internal Medicine and Therapeutics**
8 9-11 a.m.—Roosevelt Hospital, Menlo Park
22 (*Middlesex General Hospital and AMNJ*)
29
1 **Endocrine Conference**
8 3:30-5 p.m.—Rotates between Newark
15 Beth Israel Medical Center, College
22 Hospital, Newark and VA Medical
29 Center, East Orange
(*Endocrinology Section, AMNJ*)
1 **Medical Lecture Series**
8 1-2:30 p.m.—VA Medical Center, Lyons
15 (*VA Medical Center and AMNJ*)
22

- 1 **Medical Lecture Series**
8 1-3 p.m.—Christ Hospital, Jersey City
15 (*Christ Hospital and AMNJ*)
22
29
2 **Immunology '81**
9 4-6 p.m.—Institute for Medical Research
23 Copewood St., Camden
30 (*Institute for Medical Research and AMNJ*)
2 **Medical Grand Rounds**
9:30-11 a.m.—Newark Beth Israel Medical Center
(*Endocrinology Section, AMNJ*)
3 **Medical Grand Rounds**
11:30 a.m.-1:00 p.m.—College Hospital, Newark
(*Endocrinology Section, AMNJ*)
3 **Renal Conferences in Nephrology**
17 2-3:15 p.m.—College Hospital, Newark
(*Nephrology Society of NJ and AMNJ*)
7 **Inflammatory Arthritis**
8 p.m.—Burdette-Tomlin Memorial Hospital, Cape May
(*AMNJ*)
7 **Colon-Rectal Cancer**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
7 **Hypertension in the Elderly**
14 **Steroidal vs. Nonsteroidal Rx in Arthritis**
28 **Acid Base Balance and Electrolyte Disorders**
8-9 a.m.—Greater Paterson General Hospital, Wayne
(*Greater Paterson General Hospital and AMNJ*)
8 **Vector-Borne Diseases of Man and Animal**
9:45 a.m.-3 p.m.—Sheraton Inn, New Brunswick
(*NJ Public Health Association and AMNJ*)
8 **Diagnosis and Treatment of Diabetes, Including Oral Antidiabetics**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(*Dover General, Riverside and Saint Clare's Hospitals and AMNJ*)
Immunologic Mechanism of Renal Disease
8 11:30 a.m.-1 p.m.—VA Medical Center, East Orange
8 6-10 p.m.—Holiday Inn, East Orange
9 9:30-10:30 a.m.—Newark Beth Israel Medical Center
(*The Nephrology Society of NJ and AMNJ*)
10 **The Role of Prostaglandins and Kinins in Human Hypertension**
4:30-5:30 p.m.—St. Barnabas Medical Center, Livingston
(*St. Barnabas Med. Center and AMNJ*)

CMDNJ-Office of Continuing Education
COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY-NEW JERSEY MEDICAL SCHOOL
CMDNJ-New Jersey Medical School
Department of Medicine

Recent Progress In Clinical Endocrinology

MARCH 21, 1981

This course will be held in the Medical Science Building on the newly constructed \$200 million College of Medicine & Dentistry of New Jersey campus, 100 Bergen Street, Newark, New Jersey.

CLINICAL PROBLEMS IN THE DIAGNOSIS AND TREATMENT OF HYPERTHYROIDISM

GERARD N. BURROWS, M.D., Professor of Medicine
University of Toronto Medical Center, Toronto, Canada

CALCIUM HOMEOSTASIS AND THE PATHOGENESIS OF HYPERCALCEMIC DISORDERS

LOUIS M. SHERWOOD, M.D., Professor and Chairman
Department of Medicine, Albert Einstein College of Medicine
Bronx, New York

STEROID METABOLISM AND OTHER ENDOCRINE PROBLEMS IN PATIENTS WITH MORBID OBESITY

MARVIN KIRSCHNER, M.D., Professor of Medicine
CMDNJ-New Jersey Medical School, Newark, New Jersey

RADIOIMMUNOASSAY IN CLINICAL MEDICINE

ROSALYN YALOW, M.D., Nobel Prize Laureate 1977
Chairman, Department of Clinical Sciences
Montefiore Hospital, Bronx, New York

MALE HYPOGONADISM

MORTIMER B. LIPSETT, M.D., Director
National Institutes of Health Clinical Center, Bethesda, Maryland

PHEOCHROMOCYTOMA: DIAGNOSIS AND TREATMENT

NORMAN H. ERTEL, M.D., Professor of Medicine
CMDNJ-New Jersey Medical School, Newark, New Jersey

CREDIT: The College of Medicine and Dentistry of New Jersey-Office of Continuing Education certifies that this continuing medical education offering meets the criteria for 6 hours of credit in Category 1 for the Physician's Recognition Award of the American Medical Association, provided the course is completed as designed. Additionally, this course has been approved by the American Osteopathic Association for 6 credit hours in Category 2D and submitted to the American Academy of Family Practice for prescribed credits.

FOR FURTHER INFORMATION: Please contact Patricia Sarles, M.S., CMDNJ-Office of Continuing Education, 100 Bergen Street, Newark, New Jersey, 07101 (201) 456-4267

11	Phoecochromocytoma 8-10 a.m.—Newcomb Hospital, Vineland (<i>Newcomb Hospital</i>)	6	Proper Use of Blood Gases 11:30 a.m.—Rahway Hospital (<i>AMNJ</i>)	7:45 a.m.—West Jersey Hospital, Voorhees (<i>West Jersey Hospital</i>)	
14	Psychocutaneous Disorders 8 p.m.—Schering Corporation, Kenilworth (<i>NJ Dermatological Society and AMNJ</i>)	6	Medical Grand Rounds 11:30 a.m.-1 p.m.—VA Medical Center, East Orange (<i>AMNJ</i>)	15	Hemodynamics of Human Hypertension
14	Prophylactic Antibiotics	6	Dinner Meeting 6-9:30 p.m.—Holiday Inn, East Orange (<i>Endocrinology Section, AMNJ</i>)	26	Catecholamine Metabolism in Hypertension 4:30-5:30 p.m.—St. Barnabas Medical Center, Livingston (<i>St. Barnabas Medical Center and AMNJ</i>)
28	Management of Arrhythmias 12 noon-2 p.m.—West Jersey Hospital, Camden (<i>West Jersey Hospital</i>)	6	Paget's Disease of the Bone	18	The Critically Ill Patient-Early Management 12 noon-1 p.m.—Mountainside Hospital, Montclair (<i>Mountainside Hospital and AMNJ</i>)
15	Physicians' Role in Drug Abuse 8:30-4:30 p.m.—Rutgers Medical School, Piscataway (<i>AMNJ</i>)	20	Hyperlipidemia 9:30-11 a.m.—Bergen Pines County Hospital, Paramus (<i>Bergen Pines County Hospital and AMNJ</i>)	19	Fluid and Electrolyte Imbalance 11 a.m.—Greystone Park Psychiatric Hospital (<i>AMNJ</i>)
15	The Value of Screening for Lung Cancer 11:30 a.m.-1 p.m.—VA Medical Center, East Orange (<i>VA Medical Center and AMNJ</i>)	6	Dermatology in the Office Practice	19	Hypercalcemia 12 noon—St. Mary's Hospital, Orange (<i>AMNJ</i>)
15	Immunology (Clinical) 11:30 a.m.—Columbus Hospital, Newark—(<i>AMNJ</i>)	20	Hormone Secreting Tumors of the Digestive System 9:30-11:30 a.m.—St. Clare's Hospital, Denville (<i>Dover General, Riverside and St. Clare's Hospitals and AMNJ</i>)	20	Dermatological Conference 6-8 p.m.—Rutgers Community Health Plan, 57 U.S. Highway #1, New Brunswick (<i>CMDNJ</i>)
15	Dermatological Conference 6-8 p.m.—Rutgers Community Health Plan, 57 U.S. Highway #1 and Rt. 18, New Brunswick (<i>CMDNJ and AMNJ</i>)	6	Recent Advances in Internal Medicine	20	Thyroid Function and Disease 9-11 a.m.—West Jersey Hospital, Voorhees (<i>West Jersey Hospital</i>)
16	Graduate Teaching Program 5-6:30 p.m.—Somerset Medical Center, Somerville (<i>Somerset Medical Center and AMNJ</i>)	13	9-11 a.m.—Roosevelt Hospital, Menlo Park (<i>Middlesex General Hospital and AMNJ</i>)	20	Organic Acid Metabolism 4-5 p.m.—Middlesex General Hospital, New Brunswick (<i>Nephrology Society of NJ and AMNJ</i>)
20	Antibiotic Therapy in Intraabdominal Sepsis 4:40-5:30 p.m.—NJ Medical School, Newark (<i>CMDNJ and AMNJ</i>)	6	Medical Lecture Series	26	Topic to be announced 7:30-9 p.m.—Coachman Inn, Cranford (<i>NJ Blood Club and AMNJ</i>)
20	Advances in Insulin-Dependent Diabetes Mellitus 12 noon-1 p.m.—Mountainside Hospital, Montclair (<i>Mountainside Hospital and AMNJ</i>)	13	1-2:30 p.m.—VA Medical Center, Lyons (<i>VA Medical Center and AMNJ</i>)	26	Cholesterol Gallstones 12 noon-2 p.m.—West Jersey Hospital, Camden (<i>West Jersey Hospital</i>)
21	Infectious Disease 11 a.m.—Greystone Park Psychiatric Hospital (<i>AMNJ</i>)	6	Medical Lecture Series	26	Interferon, Immunotherapy 8 p.m.—Warren Hospital, Phillipsburg (<i>AMNJ</i>)
22	Management of Hypertension 9 a.m.-12 noon—St. Michael's Medical Center, Newark (<i>St. Michael's Medical Center and AMNJ</i>)	13	1-3 p.m.—Christ Hospital, Jersey City (<i>Christ Hospital and AMNJ</i>)	27	Diabetic Nephropathy 1-2:30 p.m.—VA Medical Center, Lyons (<i>VA Medical Center and AMNJ</i>)
24	Adrenal Diseases 12 noon—Freehold Area Hospital (<i>AMNJ</i>)	6	Endocrine Conferences	NEUROLOGY/PSYCHIATRY	
24	Vertigo: Diagnostic and Practical	13	3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center, College Hospital, Newark and VA Medical Center, East Orange (<i>Endocrinology Section, AMNJ</i>)	Apr.	
25	Application of Electronystagmography 8 a.m.-6 p.m.—499 Broad Street, Shrewsbury (<i>Otologic Education, Inc. and AMNJ</i>)	7	Medical Grand Rounds 9:30-11 a.m.—Newark Beth Israel Medical Center (<i>Endocrinology Section, AMNJ</i>)	1	Child Psychiatry Case Conference
25	Hemodialysis, Peritoneal Dialysis and Ultrafiltration in Management of Renal Failure 8-10 a.m.—Newcomb Hospital, Vineland (<i>Newcomb Hospital</i>)	7	Immunology	8	8:30-10:30 a.m.—Trenton Psychiatric Hospital
May		14	4-6 p.m.—Institute for Medical Research, Copewood St., Camden (<i>Institute for Medical Research and AMNJ</i>)	15	Hospital
1	Renal Conferences in Nephrology	21	Research, Copewood St., Camden	22	(<i>Trenton Psychiatric Hospital and AMNJ</i>)
15	2-3:15 p.m.—College Hospital, Newark (<i>Nephrology Society of NJ and AMNJ</i>)	8	Medical Grand Rounds 11:30 a.m.-1 p.m.—College Hospital, Newark (<i>Endocrinology Section, AMNJ</i>)	29	AMNJ
5	Peripheral Vascular Diseases 11 a.m.—Greystone Park Psychiatric Hospital (<i>AMNJ</i>)	9	Adrenal Disease	2	Family Therapy for Treatment of Adults
		23	Parenteral and Enteral Nutrition 8-10 a.m.—Newcomb Hospital, Vineland (<i>Newcomb Hospital</i>)	9	Case Presentation
		12	Metabolic Bone Disorders 8-9 a.m.—Paterson General Hospital, Wayne (<i>Paterson General Hospital and AMNJ</i>)	16	Organic Brain Syndrome in the Geriatric Population
		13	Narcolepsy 9:30-11 a.m.—Bergen Pines County Hospital, Paramus (<i>Bergen Pines County Hospital and AMNJ</i>)	23	11 a.m.-12 noon—Greystone Park Psychiatric Hospital (<i>Greystone Park Psychiatric Hospital and AMNJ</i>)
		13	Pulmonary Embolism in Geriatric Patients 2 p.m.—John E. Runnells Hospital, Berkeley Heights (<i>AMNJ</i>)	2	Borderline Syndrome
		15	New Approaches to Asthma	9	Masked Depression
				23	Agoraphobia
				30	Misdiagnosis of Schizophrenia 12 noon-1 p.m.—Carrier Foundation, Belle Mead (<i>Carrier Foundation and AMNJ</i>)
				3	Psychological Testing and Basics of Statistics
				10	Genetics and Psychiatry
				24	Genetics and Psychiatry

- 2:45-3:45 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 3 Neuroanatomy/Neuropathology and Clinical Neurology
- 10 Neuroanatomy/Neuropathology and Clinical Neurology
- 24 Medical Ethics
4-5 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 3 Psychosocial Factors in Influencing Schizophrenia
- 10 Genetics and Counseling in Psychiatric Illness
- 24 Pathologic Grief and Anniversary Reactions
12 noon-1:30 p.m.—Carrier Foundation,
Belle Mead
(*Carrier Foundation and AMNJ*)
- 3 Community Psychiatry
- 10 Community Psychiatry
- 24 Administrative Psychiatry
1:30-2:30 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 3 Psychological Testing and Basics of Statistics
- 10 Genetics and Psychiatry
- 24 Genetics and Psychiatry
2:45-3:45 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 6 Case Presentation
- 13 Modern Diagnosis and Control of the Epileptic Seizure
- 20 Neuromuscular Disease
- 27 Case Presentation
11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 6 Regression in an Adolescent Girl Following Divorce
8-10 p.m.—60 Melrose Place, Montclair
(*Essex Psychiatric Doctors Seminars and AMNJ*)
- 7 Psychiatric Case Conference
- 14 7:30-9:30 a.m.—Trenton Psychiatric Hospital
- 21 Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 8 Treatable Dementias
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 8 Outpatient Psychotherapy of Psychotic Adolescents
- 22 Diagnosis and Treatment of Hysteria
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 15 Slow Virus Infection of the Nervous System
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 15 Psychiatric Emergencies
1:30 p.m.—Trenton Psychiatric Hospital
(*AMNJ*)
- 15 A Lecture in Law and Psychiatry
- 29 Ethnicity and the New Immigrant in America

- 1:30-3 p.m.—NJ Medical School, Newark
(*CMDNJ*)
- 16 Working with Parents of Adolescents with Alcohol and/or Drug Addiction Problems
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 22 Transient Cerebral Ischemic Attacks
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- May
- 1 1-2:30 p.m.—Administrative Psychiatry
2:45-3:45 p.m.—Genetics and Psychiatry
4-5 p.m.—Medical Ethics
Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 4 A Secret in the Family
8-10 p.m.—1046 So. Orange Ave., Short Hills
(*Essex Psychiatric Doctors Seminar and AMNJ*)
- 4 Polymyositis
- 11 Case Presentation
- 18 Interictal Behavioral Disturbances in Patients with Complex Partial Seizures
11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 4 Neuroscience Conferences
- 11 11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
- 18 County Hospital, Paramus
- 25 (*Bergen Pines County Hospital and AMNJ*)
- 5 Psychiatric Case Conference
- 12 7:30-9:30 a.m.—Trenton Psychiatric Hospital
- 19 Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 26 Geriatric Psychiatry
1-3 p.m.—Ancora Psychiatric Hospital
(*Ancora Psychiatric Hospital and AMNJ*)
- 6 Ongoing Child Psychiatry Case
- 13 Conference and Lecture
- 20 8:30-10:30 a.m.—Trenton Psychiatric Hospital
- 27 Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 7 Neuropsychological Testing
- 14 Schizo-affective Illness
- 21 Outward Bound as an Adjunctive Therapy
- 28 Personality Disorders
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 7 Case Presentation
- 14 Rehabilitation and the Aged
- 21 Rehabilitation and the Aged
- 28 Rehabilitation and the Aged
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 20 Psychopharmacological Methods in Schizophrenia
1:30-3 p.m.—Community Mental Health Center, NJ Medical School, Newark
(*CMDNJ and AMNJ*)

OBSTETRICS/GYNECOLOGY

Apr.

- 1 Distinguished Lectures in Obstetrics/Gynecology
6-7 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 14 Problems in Pediatric Adolescent Gynecology
8:30 a.m.—St. Peter's Medical Center, New Brunswick
(*St. Peter's Medical Center and AMNJ*)
- 23 Pediatric and Adolescent Gynecology
4-5:30 p.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

May

- 5 Gynecological Oncology
8-9 a.m.—Paterson General Hospital, Wayne
(*Paterson General Hospital and AMNJ*)
- 6 Distinguished Lectures in Obstetrics and Gynecology
6-7 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 28 Value of Fetal Heart Rate Monitoring
4-5:30 p.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

OPHTHALMOLOGY

Apr.

- 4 Sixth Intraocular Lens Course
8 a.m.-4 p.m.—Eye Institute of NJ, Annex Bldg., Newark
(*CMDNJ and Eye Institute of NJ*)
- 15 Abnormal-Normal Eye
9 a.m.-11 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

May

- 12 Eyes in Systemic Disease
12 noon-2 p.m.—West Jersey Hospital, Camden
(*West Jersey Hospital*)

PATHOLOGY

May

- 9 Dermatopathology: A Practical Self-Assessment Course
8 a.m.-4:30 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)

PEDIATRICS

Apr.

- 1 Life-Threatening Pediatric Disease
11:30 a.m.—Rahway Hospital
(*AMNJ*)
- 17 Chronic Diarrhea in Children
7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
- 28 Pediatrics Distinguished Lecturer Series
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(*St. Joseph's Hospital and AMNJ*)
- 29 Pediatric Surgery
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)

May

- 26 Pediatrics Distinguished Lecturer Series

8:30-10:30 a.m.—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and AMNJ*)

RADIOLOGY

Apr.

- 4 **Nuclear Medicine**
8:30 a.m.-5 p.m.—Sheraton Inn, Newark Airport
(*AMNJ*)
- 4 **Basic Echocardiography**
9 a.m.-5 p.m.—Nassau Inn, Princeton
(*National Foundation for Non-Invasive Diagnostics and AMNJ*)
- 8 **Ultrasound**
2 p.m.—John E. Runnells Hospital, Berkeley Heights
(*AMNJ*)
- 8 **Neuro-Radiology Meeting**
7:45-10:15 p.m.—Morristown Memorial Hospital
(*Radiological Society of NJ and AMNJ*)
- 9 **Obstetrics**
7:30-9:30 p.m.—St. Barnabas Medical Center, Livingston
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 9 **Echography of the Mitral Valve**
7:30-9:30 p.m.—Overlook Hospital, Summit
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 16 **Bone Disease**
8 p.m.—Hospital Center at Orange
(*Radiological Society of NJ and AMNJ*)
- 20 **Radiological Evaluation of Mediastinal Masses**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 21 **Radiologic Aspects of Diseases of the Appendix**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 23 **Visiting Professorship Program**
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(*St. Barnabas Medical Center*)
- 28 **CT Scan: Other than the Head Region**
8 p.m.—Warren Hospital, Philipsburg
(*AMNJ*)
- 29 **Interventional Radiology**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)

May

- 13 **Case Presentations**
7:45-10:15 p.m.—Morristown Memorial Hospital
(*Radiological Society of NJ and AMNJ*)
- 14 **Research and Development in Ultrasound**
7:30-9:30 p.m.—Overlook Hospital, Summit
(*NJ Institute of Ultrasound in Medicine and AMNJ*)
- 16 **Advanced Echocardiography**
9 a.m.-5 p.m.—Nassau Inn, Princeton
(*National Foundation for Non-Invasive Diagnostics and AMNJ*)
- 20 **Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(*Radiotherapy Section, AMNJ*)

- 21 **Visiting Professorship Program**
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(*St. Barnabas Medical Center*)
- 21 **CT of the Kidney**
8 p.m.—The Hospital Center at Orange
(*Radiological Society of NJ and AMNJ*)

GENERAL SURGERY

Apr.

- 7 **Tumor Conferences**
12 noon-1 p.m.—Morristown Memorial Hospital
(*Morristown Memorial Hospital and AMNJ*)
- 8 **Cardiac Surgery**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 9 **Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 13 **Visiting Professor**
- 27 **Gun Shot Wounds**
4:30-5:30 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 16 **Cancer of the Esophagus**
7:30-9 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
- 29 **Pediatric Surgery**
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)

May 9

- 5 **Tumor Conferences**
12 noon-1 p.m.—Morristown Memorial Hospital
(*Morristown Memorial Hospital and AMNJ*)
- 11 **Surgical Grand Rounds**
4:30-5:30 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 13 **Non-Invasive Techniques in Evaluation of Carotid Artery Occlusion**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 14 **Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 21 **Surgical Infections: Preoperative, Perioperative and Postoperative**
7:30-9 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
- 26 **Selective Surgical Procedures for Operative Breast Cancer**
8-9 a.m.—Paterson General Hospital, Wayne
(*Paterson General Hospital and AMNJ*)

SURGICAL SPECIALTIES (includes ENT Neurosurgery, Orthopedic, Plastic, and Cardiovascular Surgery)

Apr.

- 7 **Mesenteric Vascular Disease—Colon**

5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)

- 9 **Head and Neck Surgery**
8-9 p.m.—Rancocas Valley Hospital, Willingboro
(*Burlington County Medical Society and AMNJ*)
- 21 **Heart Valve Replacement**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 29 **New Modalities of Permanent Cardiac Pacing**
9 a.m.-12 noon—St. Michael's Medical Center, Newark
(*St. Michael's Medical Center and AMNJ*)

May

- 4 **Pediatric Open Heart Surgery**
4:30-5:30 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)
- 5 **Surgical Management of Bleeding Esophageal Varices**
5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)
- 6 **Sports Medicine**
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 19 **Myocutaneous Flaps**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)
- 21 **Clinical Management of Common Sports Injuries**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)

MISCELLANEOUS

Apr.

- 7 **Hospital Dentistry**
9:30 a.m.-3:30 p.m.—NJ Medical School, Newark
(*Dental Section, AMNJ*)
- 15 **Current Malpractice Update**
11 a.m.—South Bergen Hospital, Hasbrouck Heights
(*AMNJ*)
- 22 **William P. Burbeau Annual Award Dinner**
6:30 p.m.—The Manor, West Orange
(*AMNJ*)
- 25 **Physician Update 1981**
9 a.m.-12 noon—Ramada Inn, Rt. 18, East Brunswick
(*Philippine-American Medical Society of NJ and AMNJ*)

May

- 6 **Basic Approaches to Financial Planning**
9-11 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)
- 16 **MSNJ 215th Annual Meeting**
- 19 **Meadowlands Hilton, Secaucus**
(*Medical Society of New Jersey*)
- 27 **Annual Awards Dinner**
6 p.m.—Chanticleer, Millburn
(*AMNJ*)

OBITUARIES

Dr. Francis M. Clarke, Sr.

At the grand age of 81, Francis M. Clarke, Sr., M.D., died on December 29, 1980. A native of Beaufort, North Carolina, Dr. Clarke was graduated from the University of Pennsylvania, class of 1922, and pursued a career in general surgery. He was a Fellow of the American College of Surgeons and had been on the attending staff at St. Peter's and Middlesex Hospitals in New Brunswick and the Roosevelt Hospital for Chest Diseases in Metuchen. In 1972 Dr. Clarke was a recipient of MSNJ's Golden Merit Award indicating 50 years of medical practice. He was a member of the Academy of Medicine of New Jersey and of the Philadelphia College of Physicians.

Dr. V. J. DiNicolantonio

Word just has been received of the sudden death on October 20, 1980 of Vincent J. DiNicolantonio, M.D., in Atlantic City Medical Center where he had long been associated. A native of Philadelphia, Dr. DiNicolantonio was graduated from Temple University School of Medicine in 1936 and following internship went to Atlantic City to establish a general practice with special interest in diabetes. He had retired in 1977 and was living in Brigantine. Dr. DiNicolantonio was 72 years old at the time of his death.

Dr. Samuel Fisher

On December 30, 1980 one of Passaic County's senior members, Samuel Fisher, M.D., formerly of Paterson, died in New York Hospital. A native of New York City, Dr. Fisher was graduated from the University of Maryland Medical School, class of 1930, and established a practice in dermatology in Paterson, becoming board certified in dermatology and syphilology. He was on the staff at Goldwater Memorial Hospital in New York City and Barnert Memorial Hospital in Paterson where he served also as president of the medical board.

In addition, Dr. Fisher was chief of the syphilology clinic for the board of health of Paterson. A son, Dr. Yale Fisher, is a practicing physician in New York City. Dr. Fisher had been living in retirement in Fort Lauderdale, Florida. In 1980 he was one of the recipients of MSNJ's Golden Merit Award, in recognition of his 50 years in medicine.

Dr. Casimir Gadomski

One of Union County's well-known ophthalmologists, Casimir F. Gadomski, M.D., died on December 29, 1980 at St. Elizabeth Hospital in Elizabeth, after a brief illness. A native of New Jersey, Dr. Gadomski was graduated from Jefferson Medical College in 1933 and pursued graduate work in ophthalmology and surgery of the eye, becoming board certified in that specialty. He was a Fellow of the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology and a member of the prestigious New Jersey Society of Surgeons. Dr. Gadomski had been on the staff at St. Elizabeth and Alexian Brothers Hospitals in Elizabeth and the New York Eye and Ear Infirmary. During World War II, Dr. Gadomski served in the medical department of the AUS.

Dr. Henry L. Hermann

On December 16, 1980 Henry L. Hermann, M.D., of Warren County died at his home. Born in Vienna, Austria in 1921, Dr. Hermann was graduated from Georgetown University Medical School in 1944 and pursued a residency in obstetrics and gynecology at Beth David Hospital in New York City. He came to New Jersey in 1956, after practicing briefly in Huntington, Long Island, and opened an office in Phillipsburg. He was affiliated with the Warren Hospital there. Dr. Hermann was a Fellow of the American College of Obstetricians and Gynecologists and a member of the New Jersey Obstetrical and Gynecological Society and the American Society of Abdominal Surgeons.

Dr. Jane Smith Hobson

Jane Smith Hobson, M.D., a member of our Union County component, died at her home on December 30, 1980 after a long illness. A native of Cambridge, Massachusetts, Dr. Hobson earned her medical degree from Cornell Medical College in 1948 and took residencies in adult, general and child psychiatry at New York Medical College's Metropolitan Hospital. She had been practicing in Cranford since 1969 and was on the faculty at New York Medical College in the department of child psychiatry. She was active in community affairs and served with the Division of Youth and Family Services in Elizabeth and as psychiatric consultant to the Elizabeth school system.

Dr. Robert E. Jennings

Notice has been received of the sudden death, resulting from a ruptured aortic aneurysm, of Robert E. Jennings, M.D., on November 11, 1980 at Orange Memorial Hospital. A native of New Jersey, born in 1908, Dr. Jennings was graduated from Harvard University School of Medicine in 1932 and pursued graduate studies in pediatrics becoming board certified in that field. He was a Fellow of the American Academy of Pediatrics and had been affiliated with St. Vincent's Hospital in Montclair, Children's Hospital in Newark, St. Mary's and the Hospital Center in Orange and St. Barnabas Medical Center in Livingston. Dr. Jennings was also on the faculty of the College of Physicians and Surgeons of Columbia University and CMDNJ-New Jersey Medical School, Newark. He was active in organized medicine and long had been a member of MSNJ's Committee on Child Health.

Dr. Jeffrey Lipson

At the untimely age of 38, Jeffrey Lipson, M.D., of Wayne, a member of our Passaic County component, died on December 11, 1980, after a long illness.

A native of New York City, Dr. Lipson was graduated from New York University School of Medicine in 1968 and pursued residencies in surgery and urology at Mount Sinai Hospital in New York City, becoming board certified in urology. He came to New Jersey in 1973 to establish a practice in that specialty. Dr. Lipson was affiliated with Chilton Memorial Hospital in Pompton Plains, Paterson General Hospital in Wayne, and St. Joseph's Hospital and Medical Center in Paterson.

Dr. John G. O'Brien

On December 22, 1980 John G. O'Brien, M.D., of Montclair, formerly senior attending physician at Margaret Hague Maternity Hospital in Jersey City, died at Mountainside Hospital in Glen Ridge. Born in 1919, and a native of Ohio, Dr. O'Brien was graduated from the University of Cincinnati Medical School in 1944 and pursued a career in obstetrics and gynecology. He was a diplomate of the American Board of Obstetricians and Gynecologists and a Fellow of the American College of Surgeons. He had been retired since 1975 because of physical disability. During World War II, Dr. O'Brien served with the medical department of the United States Air Force.

Dr. Bernard D. Pinck

Bernard D. Pinck, M.D., a prominent urologist and former mayor of the City of Passaic, died at St. Mary's Hospital in Passaic on January 11, after a long illness. He was a past president of the Passaic Board of Education and was a founder of the Passaic Historical Society. Born in 1916 and graduated from

Johns Hopkins University Medical School in 1941, Dr. Pinck pursued a residency in urology at New York Postgraduate Hospital and practiced that specialty in Passaic until retiring in April of 1980. He was board certified in his chosen field and a Fellow of the American College of Surgeons. He had been on the staff of Passaic General Hospital where he was director of the department of urology and was associated also with Beth Israel Hospital in Passaic, Barnert Memorial Hospital in Paterson, Chilton Memorial Hospital in Pompton Plains, and with Bellevue and University Hospitals in New York City. He also held an appointment as clinical professor of urology at New York University College of Medicine. Dr. Pinck served briefly as an associate editor of *The Journal*, MSNJ and later as a member of the Editorial Board, and contributed numerous scientific articles to that and other publications. During World War II he served with the department of medicine of the AUS.

Dr. F. Parker Willey

One of Essex County's senior members, F. Parker Willey, M.D., of South Orange, died in October of 1980. A native of Pittsburgh, Pennsylvania, Dr. Willey was graduated from Columbia University's College of Physicians and Surgeons in 1926 and pursued a practice in internal medicine, becoming board certified in that specialty. He had been affiliated with Community Hospital in Montclair, Presbyterian Hospital in Newark, and St. Barnabas Medical Center in Livingston. Dr. Willey was 79 years old at the time of his death. In 1976 he was a recipient of MSNJ's Golden Merit Award honoring his 50 years as a physician.

Dr. Daniel C. Sheehan

Word just has been received of the death on November 26, 1980 of Daniel C. Sheehan, M.D., a member of our Essex County component. A native of Massachusetts, Dr. Sheehan was graduated from Tufts Medical College in 1930 and following graduate training established a practice in pathology. He was board certified in that specialty and a Fellow of the American Society of Anatomical and Clinical Pathologists. Dr. Sheehan had been affiliated with Newark City Hospital (College Hospital), St. Michael's Medical Center in Newark, and St. Mary's Hospital in Orange. During World War II he saw service with the medical department of the United States Navy. Dr. Sheehan was 79 years old at the time of his death. In 1980 he was a recipient of MSNJ's Golden Merit Award in recognition of 50 years of service as a physician.

Dr. Walter R. Talmage

One of Morris County's senior members, Walter R. Talmage, M.D., of Morristown, died on January 7 at Morristown Memorial Hospital after a short illness. A native of Petersburg, Virginia, born in 1908, Dr. Talmage received his medical degree at Hahnemann Medical College in 1942 and pursued a residency in otolaryngology at Manhattan Eye and Ear Hospital, becoming board certified in that specialty. He was a Fellow of the American College of Surgeons and had been affiliated with Morristown Memorial Hospital, All Souls Hospital in Morristown, and the Psychiatric Hospital at Greystone Park. During World War II, Dr. Talmage served with the medical department of the AUS in the European theater.

BOOK REVIEWS

Cardiac Catheterization and Angiography, 2nd ed.

William Grossman, editor. Philadelphia, Lea and Febiger, 1980. Pp 427. Illustrated. (\$34.50)

Dr. Grossman's textbook, a revised second edition, is presented as a manual of instruction for physicians in training to become cardiologists. The twenty-four contributors represent a superb group of specialists in the field of cardiovascular diseases.

There are seven sub-divisions to the book. The first section deals with general principles which include a detailed compilation of complications and means of prevention. There are the usual sections dealing with techniques of catheterization, hemodynamic principles and angiographic techniques. A most important part of this book is the section on evaluation of cardiac functions. Dynamic and isometric exercise, atrial pacing, ventricular volume measurement, myocardial mechanics, myocardial blood flow and metabolism and His bundle recordings are discussed and illustrated with clarity. A feature not seen in other catheterization textbooks is the section on profiles of specific disorders. A problem, such as mitral stenosis, briefly is reviewed and one or more illustrative case histories are presented with the cardiac catheterization findings. One is able to assimilate individual parts of a catheterization in order to arrive at a diagnosis and make therapeutic decisions.

Major advances in cardiac catheterization within the past three years in the area of therapeutic methods have necessitated a new section in this revised edition. Percutaneous transluminal angioplasty involving peripheral and coronary arteries is discussed succinctly with several excellent illustrations. More established therapeutic techniques such as endomyocardial biopsy, balloon atrial septostomy and snaring of foreign bodies are discussed. Omitted, but surely to be included in the next edition, is reference to streptokinase intracoronary thrombolysis in acute myocardial infarction.

Dr. Grossman's book is both a textbook for the student in cardiology and a reference manual for the practitioner of cardiac catheterization. It reads easily. Concepts are conveyed concisely and clearly. It is the finest book of its size to appear on this subject.

Robert MacMillan, M.D.

Law and Emergency Care.

James E. George. St. Louis, Mosby, 1980. Pp 283. (\$24.95)

Law and Emergency Care is a succinct and clearly written volume which should be mandatory reading for emergency physicians and other health professionals involved in emergency care. Physician/attorney James E. George is uniquely qualified to have written this outstanding book. Dr. George is a practicing emergency physician at Underwood-Memorial Hospital, Woodbury, New Jersey. He received his M.D. and J.D. degrees in the same year from the University of Louisville. He is a Diplomate of the American Board of Emergency Medicine and member of the bar of New Jersey, Kentucky and the District of Columbia, and serves as Director of Professional Liability Control for the Medical Society of New Jersey, as well as Chairman of the Claims Committee of New Jersey State Medical Underwriters, Inc. He is Editor of the *Physician Legal Bulletin*, *Emergency Physician Legal Bulletin*, *Emergency Nurse Legal Bulletin* and *EMT Legal Bulletin*.

Law and Emergency Care begins with a refreshingly clear analysis of general principles of tort law as applied to medical malpractice cases. The concepts of negligence, *res ipsa loquitur*, statutes of limitations, agency, civil assault and battery and abandonment are discussed and demonstrated in the context of several medical malpractice cases. The author avoids the use of unnecessarily technical legal language and provides the reader with a clear and accurate glossary of those legal terms used.

The next fourteen chapters cover a wide range of medicolegal issues important to physicians and other health care providers. The troublesome areas of pa-

tient consent, hospital and emergency department staff responsibilities and medical malpractice insurance are discussed. Emergency physicians, emergency nurses and emergency medical technicians will find the chapters discussing emergency department records, triage, scope of practice, good samaritan laws, emergency medical technicians, child abuse, rape, emergency care and the police, psychiatric emergencies and discharge and transfer of the emergency department patient to be both enlightening and useful. Emergency department personnel may want to adapt for their own use, the sample blood alcohol specimen collection form and sample emergency department record for suspected rape, reproduced in the book's appendix.

Each of the chapters is prefaced by a concise general discussion of the medicolegal question raised and is followed by an analysis of specific legal issues as they arose in actual litigated medical malpractice cases. The interesting case examples provide insight into how courts tend to view particular emergency care situations. As a result, readers involved in emergency medical care should be better prepared to recognize potential problems and to prevent some of the problems of the past from recurring.

For all health professionals involved in emergency medical care, *Law and Emergency Care* is a book worth having.

Rudolf E. Schwaeble, M.D.

Burn Out

Herbert J. Freudenberg, Ph.D. New York, Anchor/Doubleday, 1980. Pp 214. (\$9.95)

This is a "self-help" book, enabling the reader to identify whether he is on the treacherous road to burn out. The road is indeed treacherous because one may be well on the way without realizing it.

Burn out is defined as a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward. In other words, we can burn out in the pursuit of our goals and ideals, whether they pertain to our voca-

tion or our intimate relationships. Emphasizing the latter is one of the merits of this book.

Characteristically, the candidate for burn out responds to failure in meeting his high standards for accomplishment by trying harder, thereby setting in motion the downward spiral to burn out. In the course, he will experience lack of energy, fatigue and listlessness and he is apt to withdraw in an attitude of bitterness and cynicism. He will become impatient and irritable, feeling unappreciated and unacknowledged by relatives, friends and associates. Ultimately he may fall into a state of irritable depression and develop psychosomatic complaints.

Because the burn out candidate is not apt to recognize his predicament the book gives many questionnaires, designed to aid the reader in assessing his condition. Additionally, the author gives "sound advice" in order to arrest and reverse the process of burn out.

Although the author is a psychoanalyst he relies on a psychosocial model to explain the phenomenon of burn out. He reasons that our culture overvalues high achievement and that the best, brightest and most devoted among us will fall prey to this sooner or later by extending themselves beyond what they have to give. This reviewer cannot agree. From a psychoanalytic perspective, the person prone to burn out has deep-rooted problems in regulating self-esteem. This places burn out in the category of narcissistic disorders, which certainly will not yield to a "self-help" approach. This book is misleading and cannot be recommended.

A. Johan Noordsij, M.D.

Physician Recruitment and the Hospital

Harry E. Olson, Jr. Chicago, American Hospital Association, 1980. Pp 146 (\$12—AAHA members; \$15—others)

Physician Recruitment and the Hospital outlines a comprehensive approach on the recruiting of physicians for either hospitals or communities. Although the information provided could be applied to any setting, the book is best suited to the small rural hospital or rural community.

Divided into eleven chapters the book adopts a logical sequential order to the recruitment of the physician. Starting at the determination of the need for additional manpower it goes through the

quantification of need, establishment of committees and eventually negotiating the contract.

The book provides numerous helpful hints on the process such as ways of insuring local support and the fact that "physicians can best recruit other physicians." In each area of the book useful guides are provided for the location of either additional information or assistance.

Comprehensive, yet simplistic in its approach the book would serve as a good primer and is recommended for anyone involved in the recruitment of physicians.

Ellsworth C. Havens
NJ Hospital Association

Toward the Conquest of Cancer

Edward J. Beattie, Jr., M.D. New York, Crown Publishers, 1980. Pp 278. (\$12.95)

The author of *Toward the Conquest of Cancer* is a thoracic surgeon and Chief Medical Officer of the Memorial Sloan-Kettering Cancer Center in New York. While directed primarily toward the lay public, the book has many worthwhile things to say to the medical profession. Medical students, primary care physicians, and oncologists all will find worthwhile material regarding the causes and treatment of the major cancer sites in this up-to-date publication.

Dr. Beattie's introductory format involves a case history of a newly diagnosed lung cancer patient referred to Memorial Hospital for definitive diagnosis and therapy. In minute detail the author takes us through radiologic diagnostic procedures, the bronchoscopic examination, and nuclide scanning for extent-of-disease evaluation. Of special value are the discussions between patient and physician regarding etiology, pathogenesis, details of surgical procedures, and outlook for cure, where the patient's apprehensions and medical uncertainties are discussed frankly.

Following this case presentation as a point of departure, the author marshalls the evidence for the fact that perhaps a third to a half of all cancers are preventable. This could be accomplished by avoiding the use of tobacco, excessive alcohol and tobacco in combination, as well as modifying our western style diet with high animal fat and reducing exposure to harmful chemicals in and around the workplace. Dr. Beattie

makes specific useful suggestions regarding diet and lifestyle, and recommends a schedule for physical checkups, depending upon age and sex. There is a useful summary on breast self-examination for women, as well as recommendations for avoiding or making earlier diagnosis in the other major cancers, such as colorectal cancer, lung cancer, and cancers of the male and female genito-urinary tract. There are additional chapters on newer forms of radiologic and biochemical diagnosis of cancer, as well as advances in radiotherapy and chemotherapy. In particular, Dr. Beattie's treatment of "alternative" cancer treatments, including "metabolic therapy," special diets, megavitamins, laetrile, and so on are useful and should be helpful to lay persons who are under severe stress when cancer strikes.

A large appendix of reference information regarding statistics on the major cancer sites, as well as a geographical listing of comprehensive cancer centers, clinical cancer centers, and individual community hospitals having American College of Surgeons-approved cancer programs will be of interest to the public. The book is written on an optimistic and authoritative level, and will make interesting reading for physician and patient alike.

B.J. Koven, M.D.

The Child at Risk.

Proceedings of the 19th Annual Symposium of Carrier Foundation. Belle Mead, NJ, Carrier Foundation, 1980, Pp. 99. (No price given.)

Five distinguished scholars review knowledge in five fields of medical interest related to childhood morbidity: "Schizophrenia" by Seymour Kety; "Minimal Brain Dysfunction" (known now as the "Attention Deficit Disorder") by Paul Wender; "Alcoholism" by Donald Goodwin; "Antisocial Personality" by Raymond Crowe; "Vulnerable Children" by Michael Rutter.

All but the last emphasize the importance of endogenous biological or nonexperiential factors in the pathogenesis of the conditions studied. Rutter, brilliant and iconoclastic as ever, doesn't believe that there is a syndrome of minimal brain dysfunction.

If you have the time, the articles are all well written, concise and highly accurate. All could be characterized as more informative about basic psychobiological processes than about clinical diagnosis or management.

Avrum L. Katcher, M.D.

NEEMA EMERGENCY MEDICAL —a professional association—

Emergency Medicine Positions—available with emergency physician group in Pa., N.Y., N.J., Va., W. Va., Md. and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical
Suite 400 or phone
399 Market Street in Pa., (215) 925-3511
Philadelphia, Pa. 19106 outside Pa., 800-523-0776

LOCUM TENENS WORK WANTED

THE MORE YOU KNOW ABOUT CHOICES, THE EASIER IT IS TO CHOOSE. That's why CompHealth, the oldest, largest locum tenens organization in the United States, can help make choices easier for you. With a large selection of reliable, qualified physicians to choose from, CompHealth provides physicians, hospitals, clinics and communities with dependable locum tenens coverage, allowing you to keep your practice covered without inconvenience or concern. Turn a difficult decision into an easy choice. Contact COMPHEALTH, (801) 532-1200, 175 WEST 200 SOUTH, SUITE 2003, SALT LAKE CITY, UT 84101.

FOR SALE

- Ideal parcel for a Medical Center
- You can choose from 4 to 7 acres
- Next to a Nursing Home
- Approximately one mile from the proposed St. Vincent's Hospital
- On Passaic Avenue in West Caldwell, N.J.
- Near Bloomfield Avenue, convenient to Routes 80, 280 and Eisenhower Parkway
- Call John Valentine for a copy of our detailed flyer (201) 857-2800



**VALENTINE
ASSOCIATES, INC.**
REALTORS

80 POMPTON AVENUE
VERONA, NEW JERSEY 07044

(201) 857-2800

SPRINGFIELD, NJ 25 MINUTES TO NYC

PRIVATE, FABULOUS TENNIS COURT

Large, very modern 8 room home plus 3 room finished office suite, newly decorated, 19 years young. Builder's own very "customized" custom built home. Professional all weather "Grass-Tex" Surface Court. Fireplace, huge science kitchen with charcoal grill. FEATURES TOO NUMEROUS TO MENTION. Low Taxes **\$197,500.**

BUILDER/SELLER

201-379-2840

FOR RENT

Office Space in Montville Township, New Jersey—600 plus—square feet with entrance on busy route 202. Other suites occupied by Dentist, Attorney and Real Estate Agency. Ample Parking.

201-334-8800 201-334-5431 201-227-1073

Medical/Professional Office Space

- Directly opposite Paul Kimball Hospital on major highway, Route 9, Lakewood, NJ
 - Fully carpeted and decorated
 - Reasonable terms
 - 3 vacancies: 600, 1200, 1800 square feet availability
- Call about our special equipment leasing package

Barrymor Professional Center

1200 River Ave (Rt. 9)
201-367-2226

Lakewood, NJ 08701
Chuck Moore

OFFICE SPACE FOR RENT

Office space available next to a Dental Office in a new professional building located on Main Street, Manville, New Jersey. Somerset Medical Center is five minutes away. Presently, one semi retired general practitioner in town of 14,000 plus. Presents an unusual opportunity for an immediately successful practice.

Call (201) 722-2928 for additional information.

Now Signing Leases For SPRING 1981

OCCUPANCY
SPACES AVAILABLE
10,500 sq. feet New Construction

MEDICAL/ PROFESSIONAL OFFICES

Prime Location:
MIDDLESEX COUNTY
For information call

201-828-2715

NEW JERSEY—ANCORA

Immediate openings for New Jersey licensed Staff Psychiatrists in 1000 bed JCAH and AMA Accredited Psychiatric Hospital. Affiliated with Temple University Hospital, Department of Psychiatry. Located 30 miles from Atlantic City and Philadelphia. Salary commensurate with training and experience from \$33,885 to \$50,435. Private practice after duty permitted. Liberal fringe benefits include Blue Cross, Blue Shield, and Life Insurance.

Write: Engracio Balita, M.D., Medical Director
Ancora Psychiatric Hospital
Box B
Hammonton, New Jersey 08037
or call
(609) 561-1700, Ext. 203

SEE

Classified 247
Display Ads 246

PHYSICIAN WANTED

Physician experienced in occupational or internal medicine for a full time position with a major utility. Administrative and clerical duties. Excellent salary and fringe benefits. Send curriculum vitae to Box No. 233 c/o *Journal MSNJ*

Equal Opportunity Employer

INDUSTRIAL/EMERGENCY PHYSICIAN

We are seeking a physician to augment our staff in our Trenton industrial clinic. Opportunity for advancement. Salary competitive, merit increments. Excellent benefits include malpractice and CME allowance. No night or weekend duty. New Jersey license required. Send salary requirements and curriculum vitae to Box No. 225, c/o JOURNAL MSNJ.

PHYSICIANS

All specialties. Regularly scheduled hours, respectable salary, malpractice paid, free health/dental, 30 days paid vacation, many family benefits and more. Must qualify for commissioned officer in Navy Medical Corps.

Send C. V. to
Medical Programs Officer
128 N. Broad St.
Philadelphia, PA 19102
or call
(215) 597-9680
or 564-3820.

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$16,100 to \$18,400 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

Certified Investment Gems



(WHOLESALE)



DIAMONDS SAPPHIRES
RUBIES EMERALDS
INFORMATION UPON REQUEST
(215) 364-3552

The Diamond Group Ltd.

SUITE 101, 1111 STREET ROAD
SOUTHAMPTON, PA 18966

DISABILITY INCOME-PROFESSIONAL OVERHEAD EXPENSE

Issued at ages 61-67

up to \$5000.00 per month—Professional Over-
head Expense

up to \$1000.00 per month—Disability Income

Issued subject to usual medical & participation
limits

Please call—reverse charges

Robert E. Segal, CLU

Field Representative

Monarch Life Ins. Co.,

P.O. Box 324

Mt. Freedom, N.J. 07970

Telephone (201) 992-5137

WE PUT YOUR REAL ESTATE INVESTMENT DOLLARS TO WORK FOR YOU!

Your best investment may be purchasing a condominium unit for rental purposes. We can find that exact investment property—the one that best suits your individual needs—no matter where it might be in the United States.

All across the nation, we search for condominium conversions and newly-constructed condominiums especially suitable for investment purposes. We research each project, then make our recommendations to you. Because we're there at the conception of the conversion or construction, you buy the properties at the original and lowest prices.

- We arrange for the purchase of the condominium
- We aid in obtaining your financing
- We carefully screen and find tenants for your condominium
- We arrange management of the unit for you
- WE SEE THAT YOUR DOLLARS ARE WORKING FOR YOU!

We handle the investment transaction from beginning to end. And as your representative, we minimize the responsibilities of ownership. You just enjoy the advantages:

- 100% ownership
- Appreciation of investment unit
- Obvious tax breaks—depreciation on rental property, interest and property tax deductions
- At sale, your profit is capital gains, not ordinary income

Write or call Skyline Associates for more information. A representative will contact you with everything you need to know about our services.

Skyline Associates, Inc.
72 Hickory Road
Ringwood, New Jersey 07456
201/962-6300

Please contact me with additional information about condominium investments and the services you provide.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

CLASSIFIED ADVERTISEMENTS

FAMILY PHYSICIAN—Board certified, desires solo or group practice, clinic (any kind) or state hospital practice. Write 25 Bradley Court, Indiana, PA 15701 or phone (412) 349-7233 after 5 p.m. Available April 1981.

GASTROENTEROLOGIST/INTERNIST—31, ABIM certified, university-trained in all procedures. Seeks partnership, group practice. Also general internal medicine. Available July 1981. Write Box No. 223, c/o JOURNAL MSNJ.

GENERAL SURGEON—with twenty-five years experience, interested in changing to Industrial Medicine, preferably insurance examinations; compensation or liability evaluations. Also full-time position in industry will be considered. Write Box No. 228, c/o JOURNAL MSNJ.

GENERAL SURGERY RESIDENT—Seeking General Surgery group or partnership practice, available July 1981. Board eligible. John L. Driscoll, M.D., 631 Avenue E, Bayonne, N.J. 07002.

PEDIATRICIAN—Board eligible, desires position in clinic, hospital or private practice in South Jersey area. Available immediately. Reply to Box No. 229, c/o JOURNAL MSNJ.

PEDIATRICIAN—Board certified. Seeks part-time pediatric work in any setting one weekday and/or weekend in South Jersey. Write Box No. 232, c/o JOURNAL MSNJ.

PHYSICIAN—G.P. desires part-time position (clinic, other). Available evenings and weekends. Please respond to: M.D., P.O. Box 334, Belle Mead, N.J. 08502 or telephone (201) 359-1246 evenings.

PULMONARY INTERNIST—University trained in all phases pulmonary medicine. ABIM. Seeks practice opportunity. Available July 1981. Write Box No. 209, c/o JOURNAL MSNJ.

THERAPEUTIC RADIOLOGIST—Well trained in major university hospital. Seeks independent or associate position. Board eligible. Husband, experienced physicist will also join. Available July '81. Call (212) 430-3246, Dr. Krish.

LITERATURE SEARCHES—NJMS student with graduate degrees in basic and in behavioral science desires to do literature searches in summer 1981. Write Box No. 231, c/o JOURNAL MSNJ.

RESEARCH CONSULTANT—Certified Medical Librarian will conduct all your researches and information inquiries. Call (201) 628-9119

ASSOCIATE WANTED—Family Practice Associate. Just 25 miles west of the Big Apple. Work part of the time, study or have fun the rest of the time. Make full income. Friendly town of considerate people (13,000).

A 350 bed hospital 5 minutes away. Write Box No. 230, c/o JOURNAL MSNJ.

FAMILY PRACTITIONER—Full-time, fee-for-service, 1 year free rent, to join Medical Dental Group in Trenton area. Contact Box No. 234, c/o JOURNAL MSNJ.

PEDIATRIC ASSOCIATE—New Jersey Shore area, 1 1/2 hours to New York City and Philadelphia. Write Box No. 224, c/o JOURNAL MSNJ.

PEDIATRIC ASSOCIATE—South New Jersey. Excellent opportunity to join a growing pediatric practice. Call (215) 887-6781

PHYSICIAN—Downtown Newark Industrial Clinic, Monday through Friday, 9 to 5. Good salary; excellent benefits. Call (201) 643-4969

ORTHOPEDIC SURGEON—Seeking Associate with full partnership after one year and future buy-out by 1983. North Jersey, Passaic County area. Send mailed correspondence and curriculum vitae to Mr. Harold Weiss, 354 10th Avenue, Paterson, N.J. 07514.

PRACTICE AVAILABLE—Two year old Family Practice in fast growing area in Somerset County. Close to area hospitals. Call (201) 526-7209.

PRACTICE WANTED—Bariatrics Practice wanted in Bergen, Union, Hudson, Essex or Passaic County. Reply P.O. Box J, Teaneck, N.J. 07666.

NEEDED—Used x-ray equipment, 300-500 milliamperes, in good condition with or without fluoroscopy. Call (201) 240-4031 after 5:00 p.m.

FOR SALE—Medical and Surgical Equipment. Cabinets, tables, instruments, metal desk, etc. Contents of former office. Must sell. Morris County, New Jersey. Telephone (201) 366-2557.

HOME/OFFICE For Sale—Essex County. Outstanding opportunity. Thirty-two-year-old General and Industrial Practice. Close proximity to hospital. M.D. retiring. For information call (516) 541-3800.

OFFICE/HOME for Sale—Located in Millville, New Jersey, excellent location, convenient to the hospital. Office consists of a 750 square foot suite with 2 examining rooms, doctor's office, 1/2 bath and reception room. Office occupied by established general practitioner. Office situated in a portion of residence. Home is a large three-story brick Victorian home with 10 rooms, 2 baths and a 6-car garage. Practice is negotiable. (609) 696-2255

FOR SALE—Northern Bergen County. Luxury Home/Office combination. Custom built, 4 bedrooms, 2 1/2 baths, living room, dining room, den with fireplace, pool, cabanas. Of-

fice has 500 square feet including 2 treatment rooms, bath, two entrances, waiting room, nurse and private offices. No Practice For Sale. (201) 568-4765.

FOR SALE—Home/Office. Colonial, corner, Old Freehold Road and Walchest Drive. Off street parking, separate entrances. Available three to six months. Telephone (201) 240-4444.

FOR SALE—Medical Offices. Now building, brick, modern, one story, completion June 1, 1981. Excellent parking, 6 to 8 suites available. Exciting potential for professional practice income and real estate growth. Located Northvale, New Jersey. Call (201) 768-5560.

OFFICE SPACE—For Rent, Medical Office Space, new and fully equipped, part/full time. Ocean Medical Park, Brick Town, N.J. (201) 295-9003.

OFFICE SPACE TO SHARE—with Pediatrician, Cliffside Park in Bergen County. Call (201) 945-3354.

OFFICE SPACE—Edison, New Modern Professional Building. Will divide. Need all specialties. On site parking, near all major highways. Call Dr. M. Bronstein (201) 826-5606.

OFFICE AVAILABLE—Elizabeth. Private Medical Office available immediately, 1150 square feet fully equipped and beautifully furnished and carpeted. X-ray machine, central air conditioning, parking lot, excellent location. Call (201) 643-4444 weekdays 9 to 5.

OFFICE SPACE TO SHARE—with semi-retired G.P. Ideal location in Erdman Medical building. About half-mile from exit 9, N.J. Turnpike on Route 18, East Brunswick population 35,000. Four hospitals all 10-25 minutes away. Full or part-time. Call (201) 545-4339.

OFFICE SPACE—Linden. Medical suite, 750 square feet, available. Waiting room, consultation room, three examining rooms, nurses' station, lavatory. Established location 25 years. Community need. Suburban doctor's row. Four hospitals in area. (201) 486-8653 or write Box No. 221, c/o JOURNAL MSNJ.

OFFICE SPACE—Livingston Office for rent. Immediate occupancy. For further information, please write, P.O. Box 283, Vauxhall, N.J. 07088.

OFFICE SPACE—1,300 square feet, can be divided. Growing suburban area, universities, office parks, three teaching hospitals. Ten other health professionals, including x-ray and lab in building. Madison Medical Center, 28 Walnut Street, Madison, N.J. 07940.

FOR LEASE—Professional office for lease. Excellent location, Morris County, New Jersey. (201) 366-2557.

INFORMATION FOR MEMBERS—RATES:—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance.
WORD COUNT: Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JOURNAL MSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

This publication is available in microform.



University Microfilms International

Please send additional information for _____
(name of publication)

Name _____

Institution _____

Street _____

City _____

State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

April 1981

Journal of
the Medical
Society of

New Jersey

Driving Aids for Disabled
*A. J. Reichenberger,
B.S.M.E.*

Cryosurgery for Skin Cancer
E. G. Kuflik, M.D.

Nutrition Support of
Hospitalized Patient
*M. H. Seltzer, M.D.
H. S. Fletcher, M.D.*

Edward Miller—American
Physician (1760-1812)
F. P. Chinard, M.D.

*Complete Table of
Contents on page 252*

Biosynthetic Human Insulin

The Library
Acquisitions Division
Univ. of Calif. San Francisco

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

*Check this list
against your
coverages*

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$7,500 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____

Medical Systems.

The computer system designed for individual and group practices, that does the most for your money.

The Medical System performs all the functions you'd expect—financial reports, accounts receivable, patient and third party billings—then goes far beyond these standard business systems, giving you immediate access to vital patient medical data.

Whether yours is a one physician office or a group practice representing several specialties, the Medical System is designed to help you run your office more efficiently and more professionally.

A complete financial system helps keep the business side of your practice functioning smoothly.

The Medical systems financial package is designed to meet the special needs of a thriving medical practice. Laborious tasks suddenly become much more efficient than you may think.

Consider a computerized office system that handles a variety of office accounting functions—accurately and automatically.

- Patient billing.
- Accounts receivable, A/R aging.
- Third party billing—insurance forms automatically prepared.
- Daily reconciliation of receipts and services.
- Monthly transaction summary of services and receipts.
- Daily, monthly and yearly reports.

Simply stated, Medical Systems eliminates hour after hour of seemingly endless paperwork.

All patient information is simultaneously available to both physician and staff.

This is where Medical Systems surpasses any other system now available. Designed by a physician, it goes far beyond the standard business functions and provides you with vital patient information.

A complete patient profile, last visit summary and chronic and acute illness are displayed.

There is no more searching through bulky files—you can now review every bit of patient medical information, from test results to immunization history, at the touch of a button.

Drug allergies and drug interactions—a safeguard.

The Medical System will alert the physician if a hazardous drug interaction is likely to develop with the addition or modification of drugs prescribed. It also will alert the physician to known drug allergies.

Physician scheduling and patient appointments.

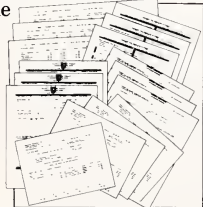
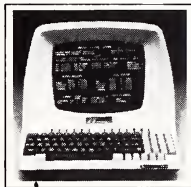
Medical Systems allows flexible appointment periods, individual schedules for physicians and staff, a two-year appointment calendar and the ability to print schedules.

It's easy to operate, easy to understand—your present staff is all you need.

Medical Systems "speaks" conversational English, not a complicated computer language. No programming or special computer skills are necessary. Medical Systems' hands-on training is all that's required.

And the complete in-office Medical System costs less than you may think.

Do this today! Mail the coupon below, or call Edward Hecht right now and let the Medical Systems professionals evaluate your needs. Then we'll explain just how economical the Medical System can be.



MEDICAL SYSTEMS, INC.

8808 Delphine Road, P.O.B. 27297
Philadelphia, Pennsylvania 19118
(215) 233-5100

I would like to learn more about the new Medical System and how I can benefit from its use in my office.

Name _____
Address _____
City _____
State _____ Zip _____
Telephone _____

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



Officers and Trustees

PRESIDENT

Augustus L. Baker, Jr., M.D. (Morris) Dover

PRESIDENT-ELECT

Armando F. Goracci, M.D. (Gloucester) Woodbury

FIRST VICE-PRESIDENT

Howard D. Slobodien, M.D. (Middlesex) Perth Amboy

SECOND VICE-PRESIDENT

Alexander D. Kovacs, M.D. (Union) Scotch Plains

IMMEDIATE PAST-PRESIDENT

Alfred A. Alessi, M.D. (Bergen) Hackensack

SECRETARY

Arthur Bernstein, M.D. (Essex) East Orange

TREASURER

Rudolph C. Gering, M.D. (Mercer) Pennington

Trustees

CHAIRMAN

William Greifinger, M.D. (1981) (Essex) Belleville

Meyer L. Abrams, M.D. (1982) (Burlington) Cherry Hill

Frank Campo, M.D. (1981) (Mercer) Trenton

Douglas M. Costabile, M.D. (1981) (Union) Murray Hill

John J. Crosby, Jr., M.D. (1981) (Hudson) Jersey City

Anthony P. DeSpirito, M.D. (1982) (Monmouth) Neptune City

Ralph J. Fioretti, M.D. (1983) (Bergen) Rochelle Park

Palma E. Formica, M.D. (1981) (Middlesex) Old Bridge

Sherman Garrison, M.D. (1983) (Cumberland) Bridgeton

John P. Kengeter, M.D. (1981) (Ocean) Toms River

Richard E. Lang, M.D. (1981) (Passaic) Passaic

Myles C. Morrison, Jr., M.D. (1982) (Morris) Morristown

John A. Surmonte, M.D. (1981) (Salem) Penns Grove

Frank Y. Watson, M.D. (1983) (Essex) Montclair

Councilors

FIRST DISTRICT

(Essex, Morris, Union, and Warren Counties)

Merton L. Griswold, Jr., M.D. (1981) Plainfield

SECOND DISTRICT

(Bergen, Hudson, Passaic, and Sussex Counties)

Robert A. Weinstein, M.D. (1983) Newton

THIRD DISTRICT

(Hunterdon, Mercer, Middlesex, and Somerset Counties)

Albert F. Moriconi, M.D. (1982) Trenton

FOURTH DISTRICT

(Burlington, Camden, Monmouth, and Ocean Counties)

Frederick W. Durham, M.D. (1981) Haddonfield

FIFTH DISTRICT

(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)

Ronald M. Fisher, M.D. (1983) Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982) Hackensack

William J. D'Elia, M.D. (1981) Spring Lake

Frederick W. Durham (1982) Haddonfield

Karl T. Franzoni, M.D. (1982) Trenton

John S. Madara, M.D. (1982) Salem

Henry J. Mineur, M.D. (1982) Cranford

April 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*

Julio C. del Castillo, M.D.

John F. Marshall, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.

Harold Arlen, M.D.

Alfonse Cinotti, M.D.

Stuart D. Cook, M.D.

Robert Dodelson, M.D.

Wm. A. Dwyer, Jr., M.D.

Norman H. Ertel, M.D.

A. Olusegun Fayemi, M.D.

Arthur Goldfarb, M.D.

Robert A. Goldstone, M.D.

Murray Kahn, M.D.

Monroe S. Karetzky, M.D.

Avrum L. Katcher, M.D.

Sidney Ketyer, M.D.

Bernard J. Koven, M.D.

Joel D. Levinson, M.D.

Henry R. Liss, M.D.

Robert M. MacMillan, M.D.

Geobel A. Marin, M.D.

Murray Nussbaum, M.D.

Christopher M. Papa, M.D.

Victor Parsonnet, M.D.

Irwin Pollack, M.D.

Bernard A. Rineberg, M.D.

Edwin L. Rothfeld, M.D.

Benjamin F. Rush, Jr., M.D.

Morris H. Saffron, M.D.

Mark M. Singer, M.D.

Leon G. Smith, M.D.

Sheldon D. Solomon, M.D.

Lloyd N. Spindell, M.D.

A. Arthur Sugerman, M.D.

Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 923. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® ^{Buccal/}5 ^{mg.} ^{Oral/}10 ^{mg.} ^{Oral/}25 ^{mg.}

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white glossy

prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

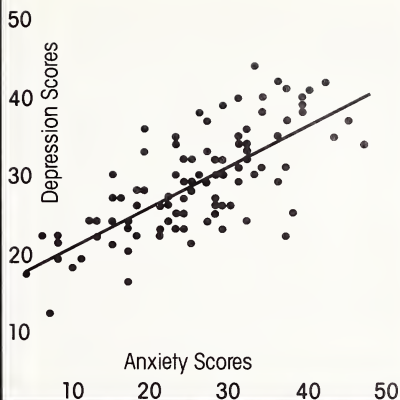
REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.

The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scales in 100 nonpsychotic psychiatric patients. The coefficient of correlation is 0.7. As depression increased, so did the anxiety levels.¹



WHY MORE PHYSICIANS ARE CHOOSING LIMBITROL

It fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician¹ found a correlation of 0.7 in anxiety and depression scores; another² has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

It is more appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression. These contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.^{2,3}

It avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Cloghorm J: *Psychosomatics* 11: 38-441, Sept-Oct 1970. 2. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. 3. Baldessarini RJ, Tarsy D: Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascia A, Killam KF. New York, Raven Press, 1978, p. 999.

in moderate to severe depression and anxiety

Limbitrol[®] IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

because it's specific for anxious depression in the nonpsychotic patient



LIMBITROL® TABLETS Tranquillizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chloridazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chloridazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely. The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extropyrizol symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.


Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, dryness, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine sulfate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chloridazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chloridazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; 161-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Packs of 50.

 ROCHE PRODUCTS INC.
Monro, Puerto Rico 00701

M.D. AUTO LEASING CO.



Catering to the Medical and allied professions

In the Greater Metropolitan area of New York



In affiliation with
Dealers Leasing Corporation

100 Birch Hill
Albertson, New York 11507
Phone: 516-484-9670

Managing Director: Daniel A. Koweity

We are fully aware of the special circumstances of the Medical Professions and offer **THREE LEASE PLANS**, for this month.

1. '81 CADILLAC COUPE DeVILLE
 2. '81 OLDS CUTLASS SUPREME COUPE
 3. '81 BUICK SKYLARK COUPE
- or tailor one to your specific needs

SPECIAL FEATURE of the Lease Plans for physicians, dentists and pharmacists, by the M.D. Auto Leasing Company—

- Special, discounted purchase price.
- Further savings on orders of 3 or more cars in a group at any one time.
- Free Loaner Car—when your car is in for service or repair.
- Interim car at reduced rates, during waiting period.
- Optional, affordable Liability insurance plan, for one million dollars.
- Optional Quality Maintenance service, of extended warranty at modest cost.
- Convenient servicing locations of your choice.
- We make "House Calls." We come to you, right in your office or home.

M.D. Auto Leasing Comp. wants to be your own auto advisory center. Whether you want to lease or buy, to sell or exchange, or to select or decide, we have the expertise to advise you & have you save.

DISCOVER THE ADVANTAGES of leasing your next new car from—

M.D. AUTO LEASING

100 Birch Hill, Albertson, New York 11507
Phone: (516) 484-9670

Featuring: Risk Management in Practice

RISK MANAGEMENT IN PRACTICE

In a recent interview with Jane Conley of the Pennsylvania Medical Society Liability Insurance Company staff, John B. Lovette, M.D., presented some suggestions for a practical, everyday approach to risk management for all physicians. Dr. Lovette is a member of the PMSLIC Board of Directors and its Claims and Loss Prevention Committee, and a past-president of the Pennsylvania Medical Society.

A major problem, Dr. Lovette believes, is the lack of physician-patient communication. He finds doctors guilty of not talking or listening enough to their patients. "I think one of the things that upsets patients is a physician who makes rounds by poking his head in the door and saying, 'How are you? That's fine. Goodbye.' Take the time to stand by the patient's side, even sit on the edge of the bed, and do some talking—don't make the patient feel that you don't have time for him (or her)."

More problem areas and, therefore, more malpractice suits, arise in group practice than in individual practice, but some of these can be avoided, according to Lovette. A partner in a two-man surgical group, Dr. Lovette said one such problem unique to group practice occurs when one partner sees a patient one day, and other partner sees the same patient the next day without discussing between them what transpired with the patient at the first visit. In cases such as this, when he hasn't seen the patient the day before, Lovette always begins his visit with the patient by asking "Well, what were you promised yesterday?" This can prevent awkward situations where, for example, a physician tells a patient he can go home today, only to find out that, yesterday, his partner told the patient he would have to stay in the hospital three more days. Dr. Lovette also recommends that physicians in a partnership arrangement avoid using the word "I" when talking to patients. Rather, he advocates the use of the word "we" when more than one physician in a group is seeing the same patient. This demonstrates a team-like approach to patient care and will help instill patient confidence, rather than making the patient think that "the right hand doesn't know what the left hand is doing."

As a surgeon, Dr. Lovette never allows his patients to be anesthetized for surgery without talking to them immediately before. "It's a standing rule in the OR that my patients can't be put to sleep, even if I'm a little late, until I get there and talk to them. I usually tell them that they're going to be alright and hold their hands a little bit. The patients really like this, and it helps to build a good physician-patient relationship."

Communication is equally as important in the office setting. "If you're seeing a patient in the office, particularly for the first time, before you take a blood pressure or have the patient get into a gown, or whatever, you ought to sit down and talk to him or her first. And the same thing applies

at the end of the office visit—always ask, 'Do you have any questions or other problems?' before the patient leaves, and then take the time to answer the patient's questions completely."

"The whole name of the game is talking to people," according to Dr. Lovette. "I live in an area that is not very urban, and I know most of the people in the area or know of their families. There is a better chance of establishing good patient-physician relationships in an area like this as opposed to Philadelphia or Pittsburgh, for example. But I still believe that, even in a big urban area like Philadelphia, a physician can get to know his patients better if he is willing to make an effort to communicate and is willing to take the time."

Reprinted with permission of PMSLIC. From *Patient Rx Newsletter*, January 1981.

VA SURGERY PATIENT AWARDED DAMAGES FOR LACK OF INFORMED CONSENT BY SURGEON

A patient was entitled to \$85,000 in damages under the Federal Tort Claims Act for the negligence of a VA physician in not informing him of the risk of severing his sciatic nerve during reconstructive surgery, a federal trial court in Missouri ruled.

The patient was a naval veteran treated at a VA hospital for injuries received in a motorcycle accident on June 28, 1975. He suffered a massive avulsive injury to his left buttock and thigh, which resulted in extensive loss of skin, muscle and subcutaneous tissue. Because of the massive nature of the buttock injury, the patient underwent several operations, including two split thickness skin grafts.

On April 26, 1976, he again underwent an operation for rotation of the skin flap, which included excision of an ischial ulcer, shave of the bone, local flap rotation and split-thickness skin graft. During the operation the physician transected the sciatic nerve, which had become encased in scarred and necrotic tissue and was impossible to detect. The patient had not been advised of the risk of injury to his sciatic nerve prior to the operation. As a result of the nerve injury, the patient had a dropfoot condition.

He filed an action against the government under the Federal Tort Claims Act, alleging negligence by the physician who severed his sciatic nerve in failing to inform him of the risks involved in the procedure. The trial court said the physician was not negligent in cutting the nerve but was negligent in failing to obtain the patient's informed consent prior to surgery. The court awarded him \$85,000 and his wife \$7,500 for loss of services, society and comfort of her

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

husband.—*Douthitt vs. U.S.*, 491 F. Supp. 891 (D.C., Mo., March 31, 1980)
(*The Citation* December 15, 1980, Vol 42, No. 5)

DID YOU KNOW

... "Some case-hungry lawyers may be turning to countersuits, or threats of them, against doctors who sue to collect unpaid bills." warns Philadelphia defense attorney James Griffith. When a client of his filed a collection suit, the patient's lawyer said he had two expert witnesses who would testify to malpractice. When they were asked, however, the experts denied ever speaking to the patient's lawyer. Says Griffith: "He thought we'd cancel the bill and settle out of court without checking the story."
(*Medical Economics* January 5, 1981)

... Pennsylvania's Supreme Court has turned mandatory arbitration of malpractice cases into a voluntary system on grounds that delays in processing claims are oppressive and infringe on constitutional rights. But the administrator of the panels says it was not too many cases that bogged down proceedings, it was the program lawyers who failed to use methods prescribed for expediting claims.
(*Medical Economics* January 5, 1981)

... In the 18 states where patients have access to information in their medical records there's been no adverse effect on

physician-patient relationships, an AMA poll of state medical associations shows. Nor do laws granting access appear to affect the quality of care, patient compliance, or the likelihood of a malpractice suit.
(*Medical Economics* January 5, 1981)

DEPARTMENT RECEIVES AMA MEDICAL SPEAKERS AWARD FOR VIDEO TAPE

The Department of Professional Liability Control received the Silver Award in Category VI of the 1980 National Awards Program for Medical Speakers, for its presentation of the video tape, "Professional Liability and the Anesthesiologist." Only 21 awards were presented, out of some 200 applicants who submitted their materials in the seven categories.

The award consisted of a check in the amount of \$500 for the Medical Society of New Jersey speakers' program and a plaque naming the Director of the Department, James E. George, M.D., J.D., as the recipient.

The video tape employs a talk show format with James E. George, M.D., J.D., as moderator and two anesthesiologists as panelists, Joseph Cox, M.D., and Harvey Hatchfield, M.D.

A number of requests have been received regarding the rental of this tape and four others produced by the Department. For more information kindly refer to the announcement below.

The Medical Society of New Jersey PRESENTS MEDICAL MALPRACTICE SEMINARS FOR AS LITTLE AS \$45.00

Professional Liability and the Obstetrician/Gynecologist
Professional Liability and the Orthopedic Surgeon
Professional Liability and the Anesthesiologist
Professional Liability and the General Surgeon
Professional Liability and Internal Medicine

The Department of Professional Liability Control of the Medical Society of New Jersey has developed *professional liability video tapes aimed at specific medical specialties*. The 3/4 inch video tapes incorporate a "talk show" format featuring James E. George, a physician-attorney, and two physicians representing the medical specialty subject of the tape. Each of the 45-55 minute 3/4 inch video tapes is designed to encourage post-viewing discussion and is available for a \$45.00 rental fee.

TOPICS INCLUDE

- General assessments of professional liability
- Informed consent
- Multiple-physician consultants
- Medical Records
- Physician to physician and physician to staff communications
- Group practice
- Emergency Room programs
- Three "R's" of malpractice prevention

Category I AMA accreditation can be obtained if the video tapes are used as part of a planned program in conjunction with a moderator.

For more information please contact the Department of Professional Liability Control at the Medical Society of New Jersey (609) 896-1766.

All tapes carry the copyright of MSNJ and may not be reproduced or distributed in any form or fashion without the express written consent of the Medical Society of New Jersey.

Copyright 1980

Bill Van Gieson has become real friendly with medical assistant Fallon.

Bill is part of our special Blue Shield professional relations staff. Bill and his colleagues specialize in answering physicians' questions, and training their medical assistants. You can depend on our professional relations staff for quick answers to your inquiries regarding claims, billing information, and contract interpretation.

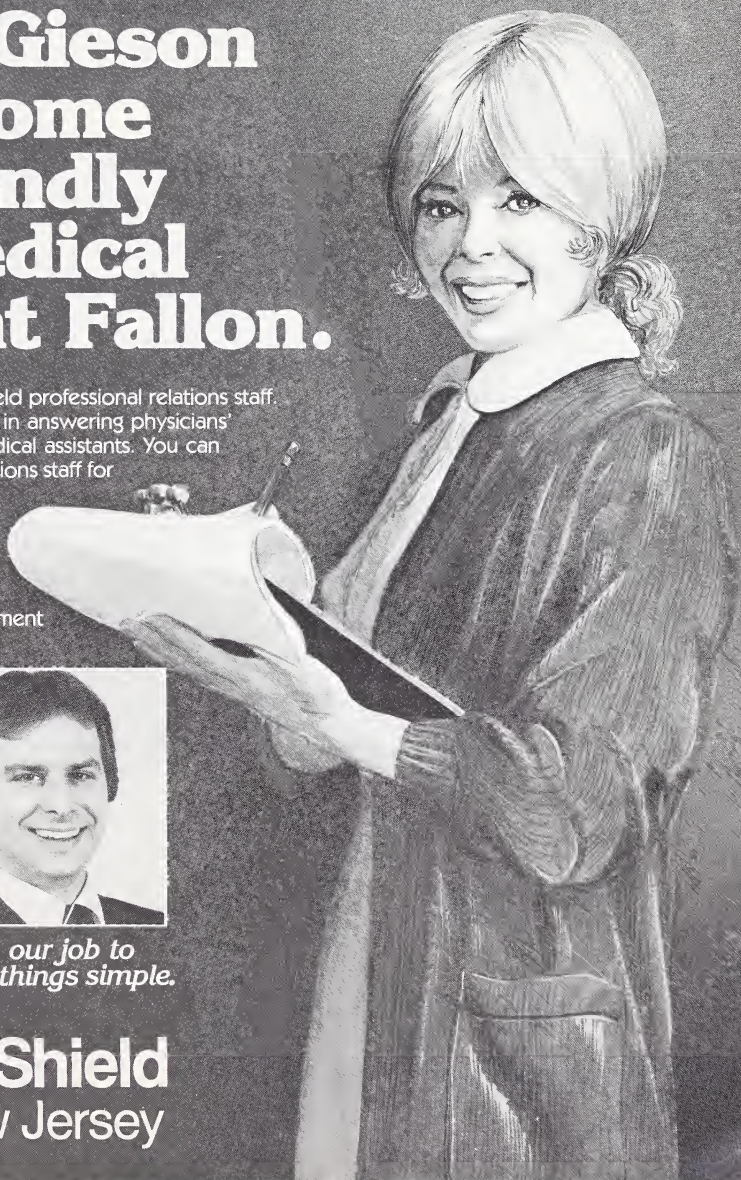
In addition, professional relations staff members handle the enrollment of new participating physicians.

So, next time you run into a Blue Shield related problem, call on us for the answer.

Be sure and visit our Blue Shield display booth (#33) at the spring meeting of the Medical Society of New Jersey - May 16-18th at the Meadowlands Hilton.



*It's our job to
make things simple.*



Blue Shield of New Jersey



Two convenient dosage forms:
100 mg (white) and 300 mg (peach)
Scored Tablets



Tablets imprinted with brand name to
assist in tablet identification.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Biosynthetic Human Insulin

Banting and Best started their quest for insulin on May 16, 1921. According to Banting, "On 11th January 1922, the first patients were treated with extract (insulin) in the Toronto General Hospital. Following the injections there was a typical lowering of blood sugar and a slight decrease of the sugar in the urine."^{*}

The first injection of biosynthetic human insulin (BHI) to be given to a diabetic patient was administered to Sandy Atherton in Wichita, Kansas under the direction of Dr. Richard A. Guthrie on December 19, 1980. The first injection of BHI to a diabetic patient east of Kansas was given to Fred W. Kostaras at Mercer Medical Center, Trenton, under the direction of this author on February 12, 1981.

Thus, the Insulin Era of the treatment of diabetes, which began in 1921, has been replaced by the Synthetic Insulin Era some sixty years later. To those who have worked in the field, this event must be considered as important as a trip to the moon. The impetus for the work that led to the production of insulin from non-animal sources was a report by the National Diabetes Commission to Congress which predicted a worldwide shortage of animal-source insulin by 1990. This conclusion was based on the relatively rapid rate of increase of insulin-treated diabetics in the United States of three to five percent annually in recent years and a probable similar rate worldwide. The accelerated growth of the insulin-treated population is based on a number of factors—longer survival, more successful pregnancies in diabetic mothers, less reliance on oral hypoglycemic drugs, and so on. The uncertainty of the supply of pancreas as a byproduct of the meat industry, with worldwide changes in the demand for meat and a relatively fixed animal (swine and cattle) supply, led to the concern about animal-source insulin.

The scientific events which resulted in this first pharmacologic agent from recombinant DNA technology to reach human use started in 1953. In that year, Watson and Crick announced to the world that the structure of deoxyribonucleic acid (DNA), the carrier of genetic material "which determines whether an organism is an eagle or an oak, a fish or a virus," was a "double helix." For that discovery they received the Nobel Prize in 1962, along with Wilkins, whose work had paved the way for theirs. The significant milestones were the following:

1956: It was demonstrated that *Escherichia coli* uses DNA as a template to synthesize more DNA for replication.

1961: It was shown that messenger RNA (ribonucleic acid) directs the synthesis of protein in the cell.

1961: Procedures were developed to isolate and purify high molecular weight DNA from bacteria and other sources.

1962: It was discovered that *E. coli* has a mechanism that protects it from foreign DNA.

1970: University of Wisconsin scientists synthesized a complete gene for the first time.

1972: Three scientists described the biochemical methods they had devised for cutting DNA molecules from two different organisms and recombining the fragments to produce functional hybrid DNA molecules.

1977: Goodman and Rutter and their team spliced a rat insulin gene into a bacterium.

1978: Eli Lilly and Company and Genentech, Inc., announced that they had succeeded in creating a synthetic gene to make human insulin.

July 21, 1980: Testing of biosynthetic human insulin made by recombinant DNA technology first was started in healthy human subjects in the United Kingdom.

In conjunction with a new drug application, an efficacy study entitled "The Use of Biosynthetic Human Insulin in the Treatment of Insulin-Dependent Diabetes Mellitus in Patients Who Have Never Received Insulin" was started by Eli Lilly and Company. The objectives are "to evaluate the efficacy and safety of Biosynthetic Human Insulin (BHI) in the treatment of insulin-dependent diabetes, and to detect, if present, immunologic evidence of *E. coli* proteins in patients who have received BHI. In addition to the Wichita center at the University of Kansas School of Medicine and the Mercer Medical Center in Trenton, study centers also are located in Detroit, Michigan at the Henry Ford Hospital, the Pennsylvania Hospital in Philadelphia and the Mason Clinic in Seattle, Washington. Ultimately, similar studies will be started at the University of Toronto and one or more centers in Europe.

Criteria for selection of treatment groups in the BHI study include male and female diabetics of all ages who previously have not received insulin and who require this form of therapy, including pregnant patients. Exclusionary factors are previous insulin therapy, life expectancy less than three years, cancer of all types, renal disease and advanced cardiovascular disease.

New Jersey is fortunate to be included in this historic step forward in the treatment and understanding of that ubiquitous disease, diabetes, which affects approximately ten million persons in the United States. It is hoped that BHI will be available for general use in a relatively short time. A.K.

^{*}Banting F: *The Early Story of Insulin*. A speech delivered on October 11, 1934 at the dedication of the Lilly Research Laboratories, Indianapolis.

DRG

Let me say at the outset that if any member of the Medical Society of New Jersey does not know what the initials "DRG" stand for, or does not know whether the Diagnostic Related Group Program is functioning in his hospital, we just will have to let him sleep.

Currently, the DRG Program now is functioning in twenty-six of the hospitals in New Jersey and the State Commissioner of Health, Dr. Joanne Finley, has ordered that more than 40 hospitals shall participate in the program. There always is hovering over us the specter that DRG will be a way of life in every hospital in the state or perhaps in the nation.

I consider Commissioner Finley's motives to be of the best and I believe that she has the public good as a primary consideration. I know she is fair-minded enough to recognize that honest objective criticism of the DRG Program will be beneficial to all concerned.

For years it was accepted that the cost inflation in health care was due to an absence of cost-containment incentives and the prevailing system of payment for patient care. There are and were basic defects in the system, we admit, including lack of equality in hospitals carrying the burden of indigent care. In addition, third-party payers were paying different rates so that some were subsidizing others. There were no uniform data on cost available so that problems could be evaluated.

Commissioner of Health Finley recognized these defects and was influential in the passage of legislation which resulted in the DRG method of hospital reimbursement.

The DRG system of reimbursement concerns physicians as well as bureaucrats, health care administrators and politicians. Keep in mind that, at some time or other, all of us will be patients and the DRG system impacts most of all on the patient. However, when regulation expands to over-regulation of the health care industry, it becomes a disease. The cause of this disease is deeply rooted in the premise that the health care system has run wild and that only through the intervention of a benevolent bureaucracy can order be maintained and the public treasury be protected. S-446/DRGs are symptoms of this disease and frontal attacks on the symptoms will not cure the disease. The elimination of DRGs would leave only a vacuum that surely would be filled with something worse. The symptoms, however, must be treated and the responsibility for reducing its worst effects rests with physicians and with hospital administrators and comptrollers.

A BRIEF EXPERIMENT

The DRG system of hospital reimbursement is complex both in its implementation and its potential for influencing patient care and the practice of medicine. No other governmental regulation is as far reaching in its potential to influence how physicians will treat patients in the future. Make no mistake about it—other states are watching closely what we do here in New Jersey in this regard. New Jersey already had mandatory hospital rate controls, but it was felt that a new way was needed to keep costs down. DRG is that method.

The present cost-reimbursement system is based on payment of the hospital for each day of care, while DRG is reimbursement at a fixed rate per diagnosis. Under the DRG system, there is an incentive to treat the patient for fewer

days and to reduce services. If the patient is discharged in a shorter period than the DRG estimated for a particular illness and is provided with less expensive care, the hospital benefits financially. If the length of stay is longer than the DRG estimate, the hospital loses money. It is as simple as that.

One year ago, twenty-six hospitals were put on the DRG Program. Only nineteen are in effect, but later forty more hospitals are to be added. Individual physicians and the Medical Society of New Jersey itself cooperated with the New Jersey Department of Health's experiment with the DRG program through its Physicians' Advisory Committee. Many physicians served on committees to develop meaningful DRG groups and the other categories involved.

We did this because we felt the Program might be innovative and helpful. It was our understanding that the DRG Program would be instituted on an experimental basis with hospitals being protected from financial loss problems. Our concern surfaced when the DRG Program became law before planning and analyses were completed. This has resulted in fear and confusion among hospital administrators and boards of trustees, the public and patients.

WHAT ARE THE DEFECTS IN THE DRG SYSTEM?

1. DRG data frequently fail to include all diagnoses and procedures and contain coding errors (35 percent). Documentation by the attending physician varies, which adds to the confusion.

2. Present DRGs reflect the state of medical technology and practice at the time of their development. With changes in medical practice and in diagnostic and treatment protocols, DRGs will become outmoded and frequently will have to be reformulated.

3. The performance of complicated procedures places a patient in a higher DRG reimbursement category. Therefore, more complex procedures are encouraged.

4. DRGs are not meaningful because they fail to recognize the standing capacity needed for high-risk patients.

5. DRG concept classifies patients into a manageable number of groups according to resource consumption based on the estimated length of stay. Factors taken into consideration are primary and secondary diagnoses, surgery, age and psychiatric service. Factors not taken into consideration are:

- a. Social and economic—the disadvantaged people may require more resources.

- b. Type of admission—patients with the same diagnosis may vary in resource consumption, depending on whether the condition is acute or chronic.

- c. Severity of illness—this affects the utilization of resources.

- d. Hospital—the quality and intensity of treatment varies with hospitals, i.e., teaching institution versus small community hospital, and so on.

6. Anomalous high bills which deviate from the norm may be presented for very short hospital stays.

One cannot deny that there is a potential in the DRG approach for improving institutional management, but the present level of sophistication of the DRG model suggests that more research and study be undertaken before its widespread use as a basis for reimbursement of hospitals be expanded.

WHAT ARE THE IMPLICATIONS OF THE DRG PROGRAM TO THE PHYSICIAN?

1. The most significant implication of DRG as a reimbursement system is further governmental regulation and control. Most people in the health care industry and most of the American public, when knowledgeable, oppose regulatory approaches to every problem. The recent elections would confirm this opinion.

2. In spite of different resource utilization, everyone pays the same hospital rate for a given DRG, whether it be Blue Cross, Medicare or a private insurance carrier.

3. There is no economic incentive for the patient to leave the hospital as soon as possible, if his bill will not be reduced accordingly.

4. Medical practice will be related to financial outcome. If hospital cost exceeds revenue, the administrators will reduce costs to survive.

5. Government agencies may use profiles to determine the services a physician should provide. Standard treatment profiles will be mandated, which will frustrate the patient who does not want treatment according to standards, but desires the treatment his physician deems advisable. When ill, every patient wants his doctor to use every resource available on his behalf.

6. Economically, it would be more profitable for the hospital to select patients with problems whose treatment cost is lower than the DRG average and to exclude cases where the cost is higher. Will the patient whose illness is likely to keep him in the hospital a long time be placed at the bottom of an admission list?

7. Cost containment will be regulated rather than legislated or voluntary.

8. The system will place hospital administrators and physicians in antagonistic roles and also will pit hospitals against hospitals and physicians against physicians.

9. Reimbursement may determine what conditions a physician may treat or which illnesses a hospital will accept.

10. Proposed regulations will set limits on the number of full-time physicians and research physicians in hospitals. Bureaucrats rather than knowledgeable physicians will make

such decisions for there is little provision for actual physician involvement in the decision-making process.

We physicians are concerned about the use of DRGs in health planning, not just reimbursement. Here lies the greater danger.

What is the role of New Jersey medicine in DRGs? The way is clear—we must join with hospital administrators. Together, we must point out how the system really works and to balance economic factors with the quality of care. Physicians must participate in the development of cost effectiveness in relation to medical decision making. It is not inconceivable that physicians may some day battle to preserve a strong local consumer voice in all health planning.

Hospitals have specified no less than nineteen major concerns as a result of their experiences in the DRG system, which will impact on each of millions of residents in New Jersey when they require health care services. Many are complaining now of the inequalities of the system. Physicians feel the DRG Program is capable of subverting health care to bureaucratic regulation. For these reasons, and to permit further study and investigation, we feel that all physicians should support Senate Resolution #49 which delays further implementation of the second phase of the DRG Program until September 15, 1981.

Fellow physicians, we will not play the strongest educational role by pounding on the table, by questioning the legitimacy of the DRG and S-446 and by demanding that the government stop interfering with the practice of medicine. We must join with hospital administration and financial experts, representatives of the Department of Health and the consumer to create an alliance for the good of the public. By explaining, by being one of, rather than one against, and by becoming a physician adviser rather than an antagonist, we will fulfill an essential role which falls only to us.

Let us point out that the system cannot work without physician help. The government decision makers need our constructive input. Let us identify solutions which will benefit the patient, the public and medicine.

Freedom will arise from the ashes of over-regulation.

Alfred A. Alessi, M.D.

Rigolosi Appointed

Too often we physicians pout, eructate, get red in the face and utter expletives (which need to be deleted) when we think and talk about the pressures of government and such extramedical organizations as the Health Systems Agency. One of our colleagues—Doctor Robert S. Rigolosi—not only has “joined them” but has taken the lead of one such body.

It recently was announced that Dr. Rigolosi, a nephrologist who resides in Paramus, was appointed as the Chairman of the five-year-old Bergen/Passaic Health Systems Agency's board of trustees. This is the kind of participation which will keep the voice of organized medicine where it belongs—among the “providers and consumers” who make major recommendations to the New Jersey State Department of Health.

By now, all physicians should realize that such federally funded panels (\$600,000 for the professional staff of the B-P

HSA) are consumer-dominated and make suggestions which impinge on individual and hospital practice in each region of New Jersey. Among the HSA responsibilities are guidance as to the purchase of expensive medical equipment, cost-care containment and improving the quantity, quality and availability of health care services.

All physicians are busy—some more than others—but it is the “shakers and the movers” like Bob Rigolosi who use their vocal apparatus, their brains and their energy in this constructive manner, who, after all, will save whatever freedom and dignity will remain in the practice of medicine in the United States.

We congratulate Dr. Rigolosi and offer him our thanks and our best wishes for a successful term as “Chairman of the Board.”

A. K.

Motrin® vs aspirin w/codeine...

(ibuprofen)



compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients.

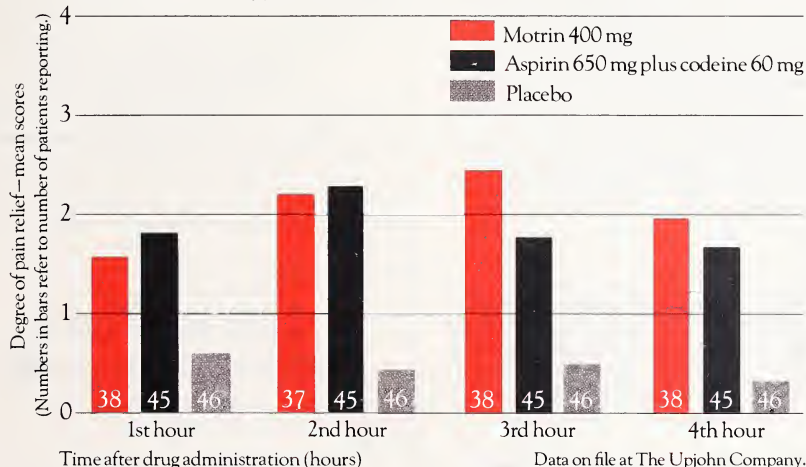
In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval.

Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief

Motrin vs aspirin-codeine combination

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



One tablet q4-6h prn

For relief of mild to moderate pain:

Motrin[®] 400 mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming • Nonscheduled
- Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may be fatal. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions: *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,^{*} epigastric pain,^{*} heartburn,^{*} diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,^{*} headache, nervousness. **Dermatologic:** Rash^{*} (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

^{*}Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

Upjohn

THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

MED B-4-S

J-8260-4

MARCH 1981

KESSLER INSTITUTE FOR REHABILITATION

West Orange, New Jersey

Affiliated with the College of Medicine and
Dentistry of New Jersey

A voluntary, non-profit specialty hospital funded in 1949 serving physically handicapped children and adults. Intensive and comprehensive medical services are provided to inpatients and outpatients; services include social, psychological and vocational services for patients with spinal cord injuries, stroke, amputations or any physical impairment due to congenital condition, accident or disease.

Total facilities include a 76-bed inpatient wing; separate outpatient department; complete hydrotherapy unit; complete speech and audiology services; comprehensive outpatient amputee and urological services.

Fully accredited by the Joint Commission on Accreditation of Hospitals and the Commission on Accreditation of Rehabilitation Facilities.

Provider of hospital services under Medicare and Medicaid.

* * * *

ADMISSION BY MEDICAL REFERRAL TO DIRECTOR OF ADMISSIONS

* * * *

RICHARD A. SULLIVAN, M.D., Medical Director

KENNETH W. AITCHISON, Executive Director

Telephone: (201) 731-3600

KATE MACY LADD CONVALESCENT HOME

Far Hills, N.J.

*Under the terms of the Will of the late
Walter G. Ladd we provide*

**"Skilled Convalescent Care
Without Charge"**

To

Ambulatory Female Patients.

Inquiries to:

Newark Office—744 Broad St.

Newark, N.J. 07102

For all information

Tel: (201) 622-1484

Over 20,000 admissions
since 1949

Barry L. Mills, FACNHA, LNHA
Administrator

Don T. Van Dam, M.D., DABFP
Medical Director

REPRESENTATIVE ROUKEMA'S TERM THREATENED

Representative Marge Roukema's victory over Andrew Maguire in Bergen County's 7th District may be short lived, according to *New Jersey Monthly*.

Because of the population shifts since the last census, New Jersey will lose one of its fifteen congressional seats. With the executive office and both houses of the State Legislature in Democratic control there is a possibility that Representative Roukema's seat will be eliminated and some strong Democratic precincts will be added to the seventh district.

SENATOR SAYS BILL WOULD PROMOTE HEALTH-CARE INDUSTRY COMPETITION

A bill to increase competition among health-care providers instead of increasing government regulation has been introduced in the Senate. Senator Orrin Hatch (R-Utah), chairman of the Senate's Labor and Human Resources Committee, authored the measure, which he says would help hold down the costs of health care and insurance, while promoting preventive health care and providing a minimum level of catastrophic health-cost protection.

Hatch's bill would:

... Encourage competition by requiring large companies to offer their employees a choice of at least three competing health plans.

... Include a 25 percent employee cost-sharing provision in at least one employee health plan, effective until medical expenses exceed 20 percent of family income. Hatch says this provision would encourage patients to participate more actively in hospital-service pricing decisions.

... Give employees a direct financial reward (such as a tax-free premium rebate) for choosing a high-deductible or other low-cost health plan.

... Provide all Americans with a minimum level of catastrophic protection, using a combination of additional prerequisites for tax-deductible insurance plans, state-administered insurance pooling arrangements and increased Medicare benefits.

... Encourage preventive care by requiring all insurance plans receiving favorable tax treatment to contain a specified minimum level of health-promotion/disease-prevention benefits, without requiring co-payments.

"We can use tax incentives to offer a tradeoff. If people are willing to pay slightly more in copayments for low-cost preventive care, they can save enough money to obtain catastrophic protection in addition," Hatch said. "They can help stop inflation of health costs without new government interference." *Washington Report* February 2, 1981.

SUNDAY ELECTIONS PROPOSED

Legislation has been introduced by Representative Mario Biaggi, (D-NY) which would provide for Sunday elections

on a trial basis. It has been introduced in both the House and Senate and awaits hearings on the proposal before the House Administration Committee. If enacted, the legislation would provide for a six-year trial period during which elections would be held in all states from noon to 9 p.m. (EST) on Sunday. Proponents of the proposed legislation cite that in Western European countries where national elections are held on Sundays, voter turnout is close to 90 percent.

JEMPAC HOTLINE USED IN PA BILL

Once again JEMPAC alerted physicians to call their New Jersey Assemblymen regarding MSNJ's opposition to *Assembly Bill 1753*. The bill if enacted would provide for the institution and regulation of the practice of Physicians' Assistants.

With the assistance of county medical societies and the JEMPAC Hotline, in cooperation with other interested professional groups, the bill would have had difficulty in being passed. Consequently, the bill's sponsor, Assemblyman George J. Otowski, (D), 19th District which is part of Middlesex, had the bill pulled from the legislative agenda.

MSNJ'S POSITION ON PROPOSED NJ LEGISLATION

Senate 1200 Eugene J. Bedell, (12th District, parts of Monmouth and Middlesex)

To provide for the licensing and regulation of dispensers of contact lens. **ACTIVE OPPOSITION**, to that portion of the bill referring to contact lenses, because MSNJ does not feel it would be beneficial to the health of the consumer. Contact lenses improperly used or fitted may cause irreparable damage to the cornea. The fitting of contact lenses should be done by the prescribing ophthalmologist or optometrist. Assigned to:

Labor, Industry and Professions Committee: Eugene Bedell, chairman, John T. Gregorio, Brian Kennedy, James Wallwork.

Assembly 1946 William J. Bate, (34th District, part of Passaic)

To permit the removal and retention of pituitary glands removed during autopsies conducted by county medical examiners and other authorized physicians. **ACTIVE SUPPORT**. Assigned to:

Institutions, Health and Welfare Committee: George J. Otowski, chairman, Raymond Lesniak, Richard F. Visotcky, Charles Mays, C. Louis Bassano, John W. Markert, Clifford W. Snedeker.

We urge you to write to the sponsors, the committee and committee members to make MSNJ's views known—c/o the State House, Trenton, NJ 08625

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

EITHER WAY

Considering an in-house computer, to handle patient accounts?

Our Medical Office Management System gives you the efficiency and reliability of modern-day technology, providing affirmative answers to all of the requirements inherent in patient/practice management. It combines the power of a computer, with a sophisticated medical management software package. It was designed to meet the needs of your practice, with the emphasis on cost feasibility and simplicity of use by your office personnel.

Here's what MOM does for you

- Improved cash flow and collection ratio
- Patient and management information on-line for inquiry
- Simplified installation and operational procedures
- Fast, efficient and reliable hardware and software
- Reduced clerical functions
- Automated Management Reports

AND MUCH MORE

State-of-the-art software and computer know-how are a winning combo.

Please call us today at 201-445-5355

MGT CONSULTANTS FOR PROFESSIONALS in

40 W RIDGEWOOD AVENUE RIDGEWOOD, NJ 07450

—YOU WIN.

Don't need an in-house computer, just the advantages of one?

We are an experienced team of professionals, prepared to offer you a computer billing service that will provide you with total visibility, accountability and confidentiality of your accounts receivables. Your patient accounts will be efficiently and profitably administered.

Here's what MCP does for you

- Fully Itemized Statements
- All Billing and Mailing functions
- Automatic Insurance Forms
- Payments and Budget Payment Plans
- Immediate Retrieval of Current Account Balances
- Telephone and written patient inquiries regarding billing statements and insurance
- Monthly Practice Analysis/Procedures Volume
- Aged Account Analysis
- Telephone Follow-Up List
- Collection List
- Financial Reports/Accounts Receivables

AND MUCH MORE

State-of-the-art software and computer know-how are a winning combo.

Please call us today at 201-445-5355

MGT CONSULTANTS FOR PROFESSIONALS inc

40 W RIDGEWOOD AVENUE RIDGEWOOD, NJ 07450

215th Annual Meeting Medical Society of New Jersey May 15-19, 1981

Housing Application The Meadowlands Hilton

Please Reserve: _____ Single _____ Double _____ Twin _____ Suite

Arrival: (date) _____ at (time) _____

Departure: (date) _____ at (time) _____

Name _____

Address _____

City _____ State _____ Zip Code _____

If double or twin name of person joining _____

Single: \$56

Twin: \$67

Double: \$67

Suite: \$150 and up

If range of rates is offered and rate requested is not available, the next available rate will be assigned. Reservations must be received no later than two (2) weeks prior to the opening date of your meeting and will be held until 6 p.m. on day of arrival unless otherwise specified.

(New Jersey Sales Tax - 5%)

Complete and mail this application to: Front Office Manager
The Meadowlands Hilton
Two Harmon Plaza
Secaucus, New Jersey 07094

Assistive Driving Aids for the Disabled

ANTON J. REICHENBERGER, B.S.M.E., New York*

A variety of adaptive automobile systems, devices, and vehicle modifications permit operation of automobiles by many handicapped drivers. We examine the "state of the art" of available adaptive automobile equipment, and the need for the standardization to assure devices that meet minimally acceptable levels of safety, quality, and performance. Some areas where further improvements are most needed are outlined, with indications of realistic future expectations to provide better mobility for the handicapped.

Adaptive automotive hand control systems are useful to many handicapped drivers who have sufficient upper-extremity strength and range of motion to operate motor vehicles independently. The Veterans Administration (VA) has complied with the intent of Congress as expressed in PL 91-666 to provide eligible handicapped veterans with standardized adaptive equipment to safely operate their personal licensed motor vehicles. For the last five years, the VA Prosthetics Center (VAPC) conducted annual compliance tests of adaptive automotive hand controls in accordance with VA standards and specifications. These yearly tests result in a list of accepted manufacturers, who supply VA beneficiaries with a variety of "add-on" control systems and devices. Since there currently are no other standards to assure the availability of adaptive automotive equipment to a minimum level of safety and quality, ongoing work is for the benefit of all VA facilities as well as the public at large.

HAND CONTROL SYSTEMS

Conventional mechanical brake-accelerator hand control systems for passenger motor vehicles are grouped into three types, i.e., push-pull, push-right angle pull, or push-twist. These distinctly different input requirements on the control handle give handicapped drivers with near normal strength and mobility of both upper extremities some choice in driving a motor vehicle. It is assumed that the motor vehicle is equipped with power brakes and power steering. Although

most "add-on" hand control systems could be installed for right-hand use, maximum driving comfort is usually achieved when the brake-accelerator control is left-hand operated. The brake-accelerator control motions for "add-on" hand controls are:

1. Push-Pull Control System (Figure 1)—To apply brakes, the driver pushes the control handle in the forward direction, parallel to the steering column. Actuation of the accelerator is achieved by pulling the same lever in the opposite direction, towards the driver.

2. Push-Right Angle Pull Control System (Figure 2)—To apply brakes, the driver pushes the control handle in the forward direction, parallel to the steering column. Actuation of the accelerator is achieved by pulling the same lever in the downward direction, towards the driver's lap.

3. Push-Twist Control System (Figure 3)—To apply brakes, the driver pushes the control handle in the forward direction, parallel to the steering column. Actuation of the accelerator is achieved by counterclockwise rotation of the handgrip.

We note that all brake control motions are similar, i.e., in the forward direction. Throttle control requires either pull, right-angle pull, or twist motions. The April, 1980 list of

*Read before the Section on Physical Medicine and Rehabilitation, 214th Annual Meeting of the Medical Society of New Jersey, May 12, 1980. Mr. Reichenberger is Chief of the Test and Development Laboratory, VA Prosthetics Center, 252 Seventh Ave., New York, NY 10001. Correspondence may be addressed to him there.

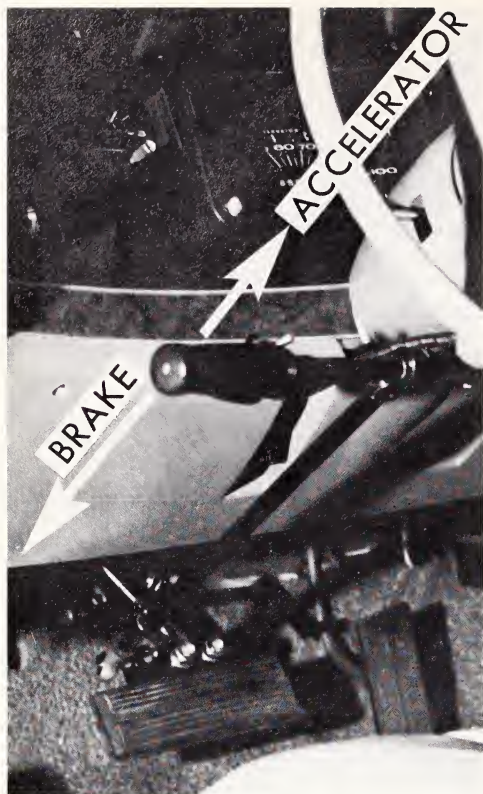


Figure 1—Push-Pull Control System.



Figure 2—Push-Right Angle Pull Control System.

adaptive automotive hand control manufacturers in compliance with VA requirements is available from the author.

STEERING ASSISTS

For handicapped drivers with nearly normal upper-limb strength and mobility but requiring some assistance in steering the motor vehicle, there are a number of devices that can be adapted simply to any standard-sized steering wheel. Figure 4 shows a typical assortment of steering assists, their usefulness much depending on available physical strength and mobility of the individual motor vehicle operator.

Much of the "add-on" automotive adaptive equipment for passenger automobiles was compiled in Program Guide M-2, Part IX, G-9, published by the Veterans Administration, Department of Medicine and Surgery, March 31, 1978. The Program Guide is listed Stock No. 051-000-00118-4, and can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, at a cost of \$2.25 per copy.

MODIFIED VANS

For handicapped drivers without sufficient strength to make the wheelchair-car-wheelchair transfer, and for those who, for any reason use an electric wheelchair, specially modified vans are available. These vehicles are normally equipped with power lifts, wheel-chair tie-down devices,

mechanical hand controls, and so on. Wheelchair lifts operate at either the right side or the rear doors of the van, and most use an electric motor as either a direct source of power for the lift or as source of power for a hydraulic pump, which in turn is used to power the lift. The Veterans Administration has promulgated standards and specifications for automatic wheelchair lift systems for passenger motor vehicles. Compliance tests of a wide variety of commercially available wheelchair lifts are currently in progress. We expect to release a list of wheelchair lift manufacturers who have met the minimum requirements for safety and quality of automotive wheelchair lift systems as soon as all testing has been completed.

The general mode of operation of a conventional van is to approach the vehicle from the curb side if it is a side loader or from the rear if it is a rear loader; operate the control system to open the doors; bring the wheelchair lift to curb or street level; drive the wheelchair into position of the lift; actuate the lift ascent control; enter the van by propelling the chair off the lift platform and into the driver's position; bring the lift back in place and close the doors; lock the wheelchair in the driving position.

Several years ago, the VA Prosthetics Center initiated an evaluation of a number of specially adapted automotive vans for wheelchair users in compliance with Public Law 93-538. At that time, there were eight sufficiently different van configurations at the start of the evaluation program to warrant individual comparative analysis of their relative merits. The purpose of the VA van evaluation program is summarized as follows:

1. To obtain experience of the relative merits of all the available van systems with particular respect to access systems, driving control, roadability, convenience of various features for individual/family use.
2. To develop government standards of safety, quality, and durability governing the purchase of vans by veterans under beneficiary entitlements.

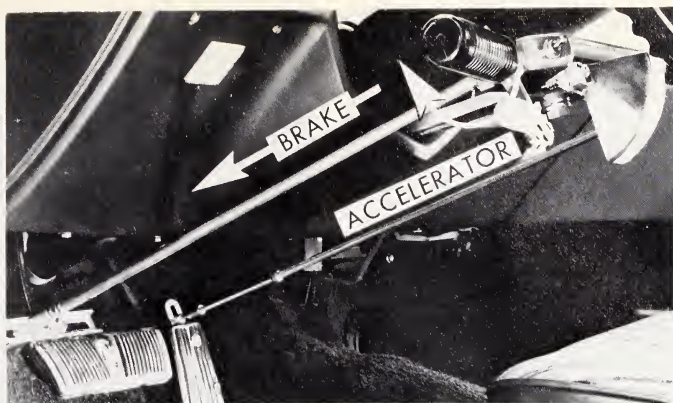


Figure 3—Push-Twist Control System.



Figure 4—An assortment of steering assists.

3. Clarification of prescription indications for various types of vans.

4. To enable qualified veterans to learn to drive, take licensing tests and to give them experience in the use of a variety of van configurations. To help them select the most appropriate vehicle for themselves.

A few typical examples of specially adapted vans used in the VAPC evaluation program are given.

Drivemaster Van (Figure 5)—Access to the vehicle is provided by a side loading lift which rotates approximately 180 degrees. The lift which is actuated from outside and from inside the van, is stored in the cargo space of the van. The

vehicle is controlled by conventional mechanical brake-accelerator hand controls.

Royce Van (Figure 6)—This van is also a side loader whose lift is a structural part of the van. In effect it combines both ramp and lift. The user lowers the lift, drives his wheelchair onto it, raises the lift to a horizontal position and rolls aboard the van; from there he raises the lift completely and, in effect, closes the "side door." The lift platform does not occupy cargo space, but the motor and housing do. One unique feature of this van is the driving seat into which the user may transfer from his own wheelchair.

Severely handicapped drivers whose residual deficits do



Figure 5—Drivemaster Van.



Figure 6—Royce Van.

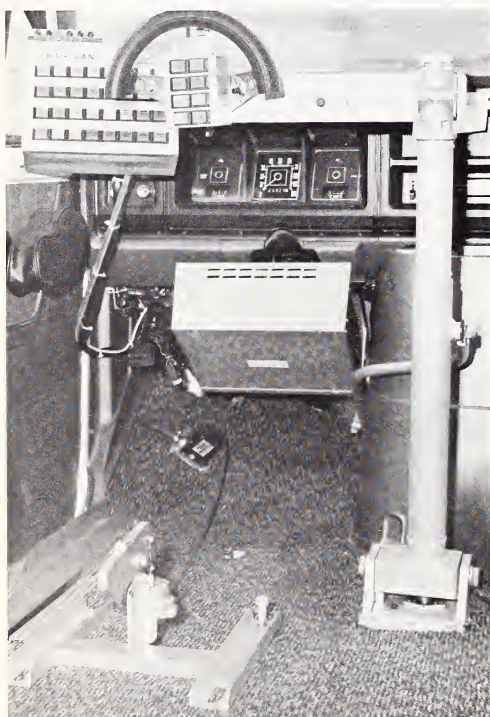


Figure 7—Med Van.



Figure 8—Electric Wheel Chair.

“Severely handicapped drivers may require a special control system to operate a personal motor vehicle.”

“... solutions to many complex problems are still to be found.”

not permit them to operate conventional hand controls, may require a special control system to operate a personal motor vehicle. There are several highly experimental and developmental control systems in our current automotive evaluation program. Nearly all power-augmented motor vehicle control systems are experimental and few are commercially available. These servo-controlled brake-accelerator or brake-accelerator-steering systems represent the most advanced motor vehicle control systems for some of our disabled drivers. A typical example of a servo-operated motor vehicle is the Med van (Figure 7). This van is quite different from the two previously shown in that it represents the archetype of a vehicle modified especially for the handicapped. The other vehicles were modified by the addition of hand controls and a wheelchair lift system. The Med van is a rear-loading type and its most unique feature is the joystick type servo control.

The ignition and the operation of all accessories, including lift and rear doors, are accomplished by actuating push buttons mounted on a panel facing the driver. Acceleration is accomplished by pushing the joystick forward and braking is accomplished by pulling it back. Rotating the small wheel steers the vehicle. A specially designed electric wheelchair is part of the motor vehicle. (Figure 8).

CONCLUSION

Progress in the area of servo-operated motor vehicle control systems appears to be modest, while solutions to many complex problems are still to be found. An optimistic projection should include some future participation by the automotive industry. Frankly, much remains to be done to improve mobility for self-sufficient handicapped drivers.

use the Experienced Laboratory



SOUTH MOUNTAIN LABORATORIES • INC

for CONTROL-RESEARCH

SERVICES IN

- PHARMACOLOGY
- ENDOCRINOLOGY
- TOXICOLOGY
- COSMETICS
- BIO-ASSAY
- PLASTIC IMPLANT
- HUMAN SKIN TESTING

380 Lackawanna Pl., South Orange, N.J. 07079 (201) 762-0045

1102 Industrial Parkway, Bricktown, N.J. 08723 (201) 458-0031

COMPARE OUR PREMIUM RATES!

\$500,000

ANNUAL RENEWABLE & CONVERTIBLE TERM INSURANCE

Age	Initial Premium
35	\$ 595
40	795
45	1,110
50	1,595
55	2,480
60	3,845

Minimum policy \$100,000

CALL OR HAVE
YOUR BROKER CALL

N.Y.C.

(212) 687-0031

N.J.

(201) 947-3100



THE INSURANCE
SUPERMARKET, INC.
RIDGEFIELD, N.J. 07657

Cryosurgery for Skin Cancer

EMANUEL G. KUFLIK, M.D., Lakewood*

Cryosurgery is an effective and safe procedure for the eradication of skin cancers. It may be used for small carcinomas, as well as for lesions which present problems in management by the usual methods of treatment.

Cryosurgery is a new method for the eradication of selected basal-cell and squamous-cell carcinomas.

This technique produces tissue necrosis through rapid freezing by the application of intense cold. Initially, chilled copper discs were used with varying results. This led to the application of liquid nitrogen as an open direct spray or through a closed probe system.¹⁻³

Liquid nitrogen, which has a boiling point of minus 196°C at atmospheric pressure, is the best cryogenic agent for treatment of skin cancer because of its ability to freeze quickly and to attain deeper destruction of tissue than other cryogens. Rapid freezing causes cellular death by reduction of the cellular metabolic rate and the change of tissue water into ice crystal formation, accompanied by cellular dehydration. Other damaging effects of liquid nitrogen are thermal shock, denaturation of lipid-protein complexes, and necrosis of tissue resulting from vascular stasis. It has been shown that cancerous tissue has a greater susceptibility to extreme coldness than normal tissue.

My experience with this method consists of treatment of over 1000 tumors since 1971.

METHOD OF TREATMENT

Treatment consists of freezing with liquid nitrogen, using cryosurgical equipment manufactured by Frigitonics. After a biopsy is obtained, treatment is carried out in one sitting in the office. No general anesthesia and little or no local

anesthesia is necessary. The lesion is outlined with a skin marker, and frozen to between minus 30°-50°C, depending upon the complexity of the tumor. The freeze should extend at least 5mm beyond the margins of the tumor and the time of freezing should last 60-90 seconds. The temperature is monitored by means of one or more thermocouple needles inserted below or at the margin of the lesion and recorded upon a pyrometer. After complete thawing of the treated site, the lesion again is frozen (double freeze-thaw cycle) to assure greater destruction of cancerous cells. Application of the liquid nitrogen may be in the form of an open direct spray of the liquid, kept in a pressurized Dewar tank, or by the use of a closed probe applied onto the lesion and held in contact with it for the desired length of time. A more recent method of monitoring the freeze is by the measurement of the electrical resistance in the treated area.^{4,5} The patient may experience some mild discomfort during the thawing-out stage.

Within 24 hours, an exudative reaction develops at the treated site which lasts into the second postoperative week. Any edema which develops can be controlled with wet compresses; secondary infection rarely occurs. This is fol-

*This paper corresponds to a scientific exhibit which was first presented at the annual meeting of the Medical Society of New Jersey, Secaucus, NJ, May 10-13, 1980. Dr. Kuflik is in private practice (dermatology) in Lakewood and Toms River, New Jersey. Correspondence may be addressed to him at 150 E. Kennedy Boulevard, Lakewood, NJ 08701.



Figure 1A—Clinical appearance of a basal-cell carcinoma on the forehead.



Figure 1B—Clinical appearance of the lesion pictured in Figure 1A during cryosurgery.



Figure 1C—Appearance of the result of cryosurgery of the lesion pictured in Figure 1A, seven weeks after treatment.

lowed by development of a dry crust which eventually loosens and falls away. Complete healing occurs in two to three weeks for facial lesions, five to six weeks for ear lesions, and up to ten to twelve weeks for trunk lesions.⁶

CRITERIA FOR TREATMENT

Most cutaneous carcinomas lie within 5 mm of the surface, and have certain clinical features with visible or palpable borders. Cryosurgery should be used only for selected tumors in which the margins are recognizable, whether they are 0.5 cm or up to several centimeters in diameter. It can be

employed for primary lesions or for recurrent tumors. Examples of tumors which are amenable to cryosurgical treatment include: (a) lesions which are difficult to treat by excision or where surgical excision may lead to mutilation; (b) where x-ray therapy might lead to necrosis; (c) where curettage and desiccation are impractical; and (d) for multiple tumors which are treated at one sitting.

Any area can be treated by means of cryosurgery. It is particularly useful for tumors of the eyelids, nose and ears, since cartilage, unlike epidermis and dermis, is rather resistant to extreme cold. Cryosurgery can eradicate the neo-



Figure 2A—Clinical appearance of a basal-cell carcinoma on the ear.



Figure 2B—Appearance of the result of cryosurgery of the lesion pictured in Figure 2A, one year after treatment.



Figure 3A—Clinical appearance of a recurrent basal-cell carcinoma on the lower eyelid.



Figure 3B—Appearance of the result of cryosurgery of the lesion pictured in Figure 3A, a year and a half after treatment.



Figure 4A—Clinical appearance of a basal-cell carcinoma on the tip of the nose in a 72-year-old man.



Figure 4B—Appearance of the result of cryosurgery of the lesion pictured in Figure 4A, six weeks after treatment.

"The cure rate of cryosurgery compares favorably with that of surgical excision, radiation therapy, and curettage and desiccation . . ."

plasm while preserving the normal configuration of the organ.

There are no contraindications for cryosurgery, except a history of cold urticaria, cryofibrinogenemia, or any untoward reaction from previous "freezing" treatment.

RESULTS

The cure rate of cryosurgery compares favorably with that of surgical excision, radiation therapy, and curettage and desiccation, which has been reported to be 95 percent or better when employed by skilled physicians.⁷ Zacarian, in treating a very large number of cases by cryosurgery, found a cure rate of 97 percent.⁸ The author, in a study involving 44 basal-cell carcinomas of the eyelids and canthi, found a cure rate of 96.7 percent, and 100 percent in a group of basal-cell carcinomas on the tip of the nose.^{9,10}

Wound healing is excellent, with no development of keloid formation. Hypopigmentation may occur, especially on the nose, forehead, and helix of the ear, but has not been a source of dissatisfaction to my patients.

The accompanying illustrations are representative of the lesions treated and the results achieved.

CONCLUSION

Cryosurgery is simple to use, and is suitable for small epitheliomas, as well as for cutaneous cancers which present problems in management by the usual methods of treatment. The cure rates for lesions treated by cryosurgery at different anatomic areas are comparable to those reported by the use of surgical excision, x-ray therapy, and curettage and desiccation. Wound healing is excellent, although hypopigmentation may occur.

REFERENCES

1. Torre D: Cradle of cryosurgery. *NY J Med* 67:465-467, 1967.
2. Zacarian SA: *Cryosurgical Advances in Dermatology and Tumors of the Head and Neck*. Springfield, Charles C. Thomas, 1977.
3. Zacarian SA: Cryosurgery of skin cancer: Fundamentals of technique and application. *Cutis* 16:449-460, 1975.
4. LePivert PJ: The measurement of low frequency electrical impedance as a guide to effective cryosurgery. *J Dermatol Surg Oncol* 3:395-397, 1977.
5. Savic M and Zacarian SA: A new impedance-based method for controlled cryosurgery of malignant tumors. *J Dermatol Surg Oncol* 3:592-593, 1977.
6. Elton, RF: The course of events following cryosurgery. *J Dermatol Surg Oncol* 3:449-451, 1977.
7. Popkin GL, DeFeo CP: Basal cell epithelioma, in Andrade R, Gumport S, Popkin GL, and Rees TD (eds): *Cancer of the Skin*. Philadelphia, Saunders, 1976, p. 842.
8. Zacarian SA: Cryosurgery for cancer of the skin, in Zacarian SA (ed): *Cryosurgical Advances in Dermatology and Tumors of the Head and Neck*. Springfield, Charles C. Thomas, 1977. pp 140-142.
9. Kuflik EG: Cryosurgery for basal-cell carcinomas on and around eyelids. *J Dermatol Surg Oncol* 4:911-913, 1978.
10. Kuflik EG: Treatment of basal and squamous cell carcinomas on the tip of the nose by cryosurgery. *J Dermatol Surg Oncol* 6:811-813, 1980.



works well in your office...

NEOSPORIN® Ointment (polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.

- It contains three antibiotics that are rarely used systemically.

- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

WE PUT YOUR REAL ESTATE INVESTMENT DOLLARS TO WORK FOR YOU!

Your best investment may be purchasing a condominium unit for rental purposes. We can find that exact investment property—the one that best suits your individual needs—no matter where it might be in the United States.

All across the nation, we search for condominium conversions and newly-constructed condominiums especially suitable for investment purposes. We research each project, then make our recommendations to you. Because we're there at the conception of the conversion or construction, you buy the properties at the original and lowest prices.

- We arrange for the purchase of the condominium
- We aid in obtaining your financing
- We carefully screen and find tenants for your condominium
- We arrange management of the unit for you
- WE SEE THAT YOUR DOLLARS ARE WORKING FOR YOU!

We handle the investment transaction from beginning to end. And as your representative, we minimize the responsibilities of ownership. You just enjoy the advantages:

- 100% ownership
- Appreciation of investment unit
- Obvious tax breaks—depreciation on rental property, interest and property tax deductions
- At sale, your profit is capital gains, not ordinary income

Write or call Skyline Associates for more information. A representative will contact you with everything you need to know about our services.

Skyline Associates, Inc.
72 Hickory Road
Ringwood, New Jersey 07456
201/962-6300

Please contact me with additional information about condominium investments and the services you provide.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

a group major medical plan for doctors

Officially Endorsed by The Medical Society of New Jersey

**BROAD COVERAGE
COMPETITIVE RATES
OPEN ENROLLMENT
JUNE AND DECEMBER**

For More Information Contact
Donald F. Smith and Associates

1 Airport Place, Route 206 North, P.O. Box 2197 • Princeton, New Jersey 08540 • (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross-Blue Shield

The Forgotten Orifice

PAUL E. STROUP, M.D. Camden*

The routine pelvic examination provides an excellent opportunity to detect urethral disease. Urethral stenosis is a common finding and frequently symptomatic. Treatment is simple and produces relief of symptoms in about eighty-five percent.

Distal urethral stenosis is a common finding in gynecologic practice. Yet postgraduate medical programs seldom stress observation of the urethral meatus as an important part of a "routine pelvic examination." Some purport a relationship between urethral stenosis and recurrent cystitis.¹ Others stress the multifactorial etiology of recurrent cystitis and tend to downgrade the importance of urethral obstruction.^{2,3} Regardless of the role of meatal stenosis in recurrent urinary tract infection, about eighty percent of patients with stenosis have one or more symptoms.

SYMPTOMS

The symptoms associated with urethral meatal stenosis may be intermittent or constant; they include difficulty initiating the stream, urgency, double voiding, nocturia and urgency incontinence. Occasionally, the latter is difficult to distinguish from urinary stress incontinence. The most common symptom is urgency. Although this symptom is pressing, it seldom is the primary reason a patient consults a physician.

DIAGNOSIS

Diagnostic techniques have to exclude congenital urethral valves, urethral ectopy, non-obstructive cystourethritis, urethral diverticulum, urinary calculi and tumors, cystourethrocele and neurologic disorders.

The diagnosis of urethral stenosis is suspected by observing a small meatal opening which stretches to three mm or less. It can be confirmed by noting meatal blanching with French sounds 22 to 26¹. Urologic study usually discloses a normal urinalysis, culture and intravenous pyelogram.⁴ Cystoscopic examination seldom is normal, the most common finding being trigonitis. In some instances polypoid urethritis and bladder trabeculation are found.

Current study of this problem has included urodynamic techniques such as cystometry and urethral profilometry.⁴ Cystometry employs a double lumen catheter for constant rate filling of the bladder with water or carbon dioxide and simultaneous kymographic recording of bladder pressure. Occasionally, rectal and anal sphincter probes also are used to measure intraperitoneal and pelvic floor pressures. The recording is marked at the initial desire to void, bladder fullness and the absolute need to void. Instead of a normal flat tracing during bladder filling, patients with urethral stenosis frequently demonstrate intermittent peaks. This is thought to be a reflection of the trigonitis. A urethral pressure profile is obtained by withdrawing a single lumen catheter from the inside of the bladder to the external urethral meatus at a constant rate. A constant flow of water or carbon dioxide is maintained during the procedure. Recordings are made with an empty, partially full and full

*Dr. Stroup is attending obstetrician, Cooper Medical Center, Camden. He may be addressed at 618 Benson St., Camden, NJ 08103

"The diagnosis of urethral stenosis is suspected by observing a small meatal opening which stretches to three mm or less."

"The aim of therapy is to enlarge the external urethral meatus by stretching, incising or excising a portion of the thick distal periurethral connective tissue."

bladder. Patients with urethral stenosis frequently have a high midurethral pressure. This seems to be related to the meatal stenosis because it gradually disappears after correction of the stenosis.

TREATMENT

Treatment of urethral stenosis should be undertaken only when the symptoms are progressive and not due to another abnormality. The aim of therapy is to enlarge the external urethral meatus by stretching, incising or excising a portion of the thick distal periurethral connective tissue. This can be accomplished by dilatation (French 32—34), urethrotomy or urethroplasty. Dilatation requires at least two office visits, while the others require hospitalization. Appropriate antibiotic treatment and followup must be continued until the trigonitis clears or, in cases of recurrent cystitis, until two consecutive cultures are normal.

When urethral stenosis is associated with incontinence, no attempt should be made to treat the incontinence until the stenosis is resolved. Often the incontinence will disappear after successful meatal surgery. Also, some patients with incontinence will respond to medical treatment alone⁶. Beck treated 64 patients with culture-negative unstable bladders with an anticholinergic drug, propantheline bromide^a in a dose of 15 mg. q.i.d., for three weeks.⁵ After the treatment interval these patients were reevaluated by cystometry. Fourteen were considered "cured" (no clinical incontinence nor bladder instability) and 35 "improved." However, there was no associated improvement in bladder capacity. One patient considered "improved" had a reduced bladder capacity. The same study demonstrated that twenty percent of such patients improved with placebo medication alone. Hasty surgery (anterior colporrhaphy or ventral suspension) for incontinence not only may fail to cure but may aggravate the incontinence.

COMMENT

Inspection of the urethra and the meatus should be a part of every pelvic examination. External meatal stenosis is a common finding and frequently symptomatic. Invasive procedures, which have the potential for infection, are necessary to establish the diagnosis of stenosis. Because of this the patient's history and severity of symptoms must be weighed carefully before proceeding. Cystometry and urethral profilometry have contributed to the understanding of urethral

stenosis, especially those cases associated with unstable bladder incontinence. Treatment of the stenosis, with or without anticholinergic drugs, may cure this type of incontinence and make surgery unnecessary. The complex nature of urinary bladder control is attested to by the improvement in patients with unstable bladder incontinence with placebo treatment alone.

Enlarging the urethral meatus in patients with urethral stenosis, regardless of the procedure employed, will produce symptomatic relief in eighty-five percent. If resolution of recurrent urinary tract infection is used as the endpoint, then the efficacy of meatal enlargement is less certain^{2,6}. The recurrence of urinary tract symptoms in some patients, despite successful meatal surgery and the absence of other urinary tract abnormalities, demonstrates that the complete role of urethral stenosis in female pelvic pathology is uncertain.

SUMMARY

Urethral meatal stenosis frequently is associated with urinary hesitancy, double voiding, urgency, nocturia and incontinence. The diagnosis, suspected on pelvic examination, can be confirmed by urologic evaluation.

Enlargement of the urethral meatus will produce relief of symptoms in eighty-five percent and cure some cases of chronic urinary tract infection and unstable bladder incontinence. Inspection of the urethra and the external meatus should be a part of every pelvic examination.

REFERENCES

1. Seddon JM, Bruce AW: Cystourethritis. *Urol* 11:1-10, 1978.
2. Graham JB, King LR, Kropp KA, Uehling DT: The significance of distal urethral narrowing in young girls. *J Urol* 97:1045-1049, 1967.
3. Stamey TA: Urinary tract infections in women, in J. Hartwell, et al (ed): *Campbell's Urology*, vol. 1, Philadelphia, Saunders, 1978, pp 451-479.
4. Marchant DJ: Urinary incontinence in the female. *Hosp Med* 13:60-91, 1977.
5. Beck RP, Arnusch D, King C: Results in treating 210 patients with detrusor overactivity incontinence of urine. *Am J Obstet Gynecol* 125:593-596, 1976.
6. Kaplan G, Sammons TA, King L: A blind comparison of dilatation, urethrotomy and medication alone in the treatment of urinary tract infection in girls. *J Urol* 109:917-919, 1973.

^aPro-Banthine®, Searle

An added complication... in the treatment of bacterial bronchitis*

Increasing incidence
of ampicillin resistance in
Haemophilus influenzae

Ampicillin Resistant
Haemophilus influenzae

H. influenzae

S. pneumoniae

Brief Summary
Consult the package literature for prescribing information.

Indications and Usage: Ceflor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (diplococcus pneumoniae), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceflor.

Contraindication: Ceflor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS. CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. ANOTHER ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceflor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents (e.g., pressor amines, antihistamines, or corticosteroids).

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceflor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceflor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinette® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no fetotoxic or antiproliferative effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established.

The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Lactation: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceflor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceflor.⁷

Ceflor®
cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia or thrush, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 30 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceflor (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients. Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. *Antimicrob. Agents Chemother.*, 8:91, 1975.
2. *Antimicrob. Agents Chemother.*, 11:470, 1977.
3. *Antimicrob. Agents Chemother.*, 13:584, 1978.
4. *Antimicrob. Agents Chemother.*, 12:150, 1977.
5. Current Chemotherapy (edited by W. S. Hoogstraal and R. L. W. Hoogstraal), 11:880. Washington, D.C.: American Society for Microbiology, 1978.
6. *Antimicrob. Agents Chemother.*, 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases, edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett, p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from:
Eli Lilly and Company
Indianapolis, Indiana 46205
Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Lilly

100061

Agoraphobia: The "What If" Syndrome

MORTON FIER, M.D., Hackensack*

Agoraphobia, manifested by fear of leaving home and panic attacks, is a very common condition. The phobic patient develops extensive secondary, avoidance mechanisms which complicate the clinical condition and sometimes obscure the diagnosis. Agoraphobics often respond dramatically to treatment with imipramine (Tofranil®) or phenelzine (Nardil®).

Agoraphobia has been defined as a fear of open spaces. The classical definition, when viewed in terms of the protean behavioral manifestations, seems overly restrictive. The outstanding feature of the disorder is a fear of leaving home. A brief descriptive paragraph taken from the *Diagnostic and Statistical Manual of Mental Disorders III*¹ will serve to clarify and redefine agoraphobia in more meaningful terms:

"The essential feature is a marked fear of being alone, or being in public places from which escape might be difficult or help not available in case of sudden incapacitation. Normal activities are increasingly constricted as the fears or avoidance behavior dominate the individual's life. The most common situations avoided involve being in crowds, such as on a busy street or in crowded stores, or being in tunnels, on bridges, on elevators, or on public transportation. Often these individuals insist that a family member or a friend accompany them whenever they leave home."²

"The panic attacks are manifested by the sudden onset of intense apprehension, fear or terror, often associated with feelings of impending doom. The most common symptoms experienced during an attack are dyspnea, palpitations, chest pain or discomfort, choking or smothering sensations, dizziness, vertigo, or unsteady feelings, feelings of unreality (depersonalization or derealization), paresthesias, hot and cold flashes, sweating, faintness, trembling or shaking, and fear of dying, going crazy or doing something uncontrolled

during the attack. Attacks usually last minutes; more rarely, hours."³

Two distinct phases of the agoraphobic disorder are typically noted. After experiencing one or more frank panic attacks, the patient becomes aware of significant anticipatory anxiety. The victim becomes increasingly fearful that given situations may precipitate panic attacks, and seeks to avoid those situations. That is to say, the patient anticipates a panic attack and engages in behavior calculated to avoid all those situations perceived as threatening. The typical agoraphobic patient can only venture into those situations perceived as threatening when accompanied by a trusted friend or relative. On occasion, an agoraphobic person may become secondarily depressed with the awareness of the significant restriction of freedom of movement and activity. Though the disorder more frequently affects women, men are not immune. In my practice the ratio of women to men is about 10:1.

ETIOLOGY

Gelder and Marks describe the typical agoraphobic as a dependent personality, usually female, and with a history of frequent separation anxiety as a child.⁴ The separation

*Dr. Fier is Associate Director, Department of Psychiatry, Hackensack Hospital and Associate Clinical Professor of Psychiatry, CMDNJ, New Jersey Medical School, Newark. Correspondence may be addressed to him at 185 Prospect Avenue, Hackensack, N.J. 07601.

"Some women who suffer with agoraphobia have prostitution fantasies while out on the street."

"It has been suggested that two million Americans may be severely incapacitated by phobic symptoms."⁴

anxiety may be manifest as school phobia, fear of sleeping away from home, inability to attend sleep-away camp and an unusually close attachment to mother.

Redlich and Freedman state in their book: "It is now widely accepted that adult phobias are modified repetitions of those in infancy, often reinforced by parental phobias. Phobias, of course, are a prime demonstration of the mechanisms of spreading displacement so that the original fear attaches to ever more remote and implausible substitutes".³ Reference is made to Freud's famous study of Little Hans, a five-year old boy with symptoms of agoraphobia and fear of horses. The child feared his father as a rival for his mother's attention. The desire to eliminate his father as a rival created intensely uncomfortable feelings which in turn were partly dissipated by development of an agoraphobia which permitted him to remain at home, close to his mother. The fear of horses enabled the child to displace to an animal his fear and aggression concerning his father, thus permitting him to cope with his father's presence at home. Some women who suffer with agoraphobia have prostitution fantasies while out on the street. The inability to go out therefore serves as a defense against sexual promiscuity.

Pitts and McClure demonstrated that acute anxiety attacks could be precipitated by intravenous infusion of a sodium lactate solution in an identified, vulnerable population.⁶ This interesting study may suggest a biological vulnerability in patients who are prone to panic attacks.

RECOGNITION

It has been suggested that two million Americans may be severely incapacitated by phobic symptoms.⁴ Because many of these patients assiduously avoid phobic situations, few people are aware of their significant morbidity. Avoidance, alcoholism, and abuse of anxiolytic drugs are common attempts to cope with the crippling anxiety. Though anxiolytic drugs may be beneficial in diminishing the acute anxiety, they offer no benefit in terms of prevention of future attacks.

The anticipatory anxiety described earlier gives rise to the "what if" syndrome. The panic attacks, with fears of imminent death, are so frightening that the agoraphobic patient avoids any situation remotely perceived as a possible precipitant of an attack.

"If I go to the movies and sit in the middle of the row," the phobic ponders, "What if I get an attack? How will I get out? Who will help me? Who will get medical aid?" In a theatre the phobic patient always will sit on the aisle where ready exit is possible. "What if I get an attack in church" prompts the phobic church-goer to stand at the back of the church during services. When driving a car, service roads are often preferred to highways because the next exit may be miles away.

"What if I get an attack trapped miles from the next exit?" The phobic gradually becomes unable to walk alone, drive a car, visit large shopping centers, walk streets, travel away from home, and generally to engage in any independent activities. Some brief illustrative clinical vignettes follow:

CASE 1

A 35-year old, married male, the father of five children was referred for psychiatric evaluation after being brought by ambulance to the hospital emergency room three times in one week with complaints of chest pain, hyperventilation and fear of a heart attack. A successful businessman, he was forced to travel internationally. Prior to leaving for each trip, he set up a rigid schedule of business meetings at his destination. On arrival he went directly to his hotel room where he carried out all his business meetings. He ate in his room, never went sight-seeing, and caught the first plane home after completing his business. Though having traveled all over the world he literally could not differentiate between Paris, Taiwan or Mexico City, but for the signs at the airport. What could have been a rather exciting position evoked only dread in this man. "What if I get sick while I'm away? What if I start to choke in a restaurant," and so on.

CASE 2

A 38-year old, married female, the mother of two pre-adolescent daughters, when first seen, was virtually a prisoner in her own home. Unaccompanied she could only venture out as far as her front porch. She had to depend on her husband to accompany her in all activities which took her out of the house.

CASE 3

A 35-year old, successful businessman, when walking to the bank to transact business literally would hold on to the walls of buildings lining the street enroute. Once in the bank, if he could walk directly to the teller's window where he would be able to hold onto the ledge, it would be possible to carry out the transaction. If it were necessary to wait in line, unsupported, he became light-headed, dizzy, panicky and forced to leave. Similarly, waiting for a table in a restaurant became an ordeal to be avoided.

CASE 4

A 17-year old, single, female, was referred for evaluation because of increasing anxiety attacks and inability to attend school. She was a high school senior with a prior history of separation anxiety and school phobia. Her anxiety attacks were related to fears of graduating from the high school in which she had become comfortable and felt safe. Graduation meant leaving the safety of school and either going to work

or away from home to attend college. She experienced dizziness, nausea, vomiting, feelings of depersonalization and weight loss.

TREATMENT

For many years psychiatrists felt that phobic disorders could only be treated by exploratory psychotherapies. It was reasoned that the phobia was a symbolic expression of an underlying conflict. Psychotherapy was directed toward bringing the unconscious conflicts into consciousness and thereby allowing the patient to "work through" the conflicts.

In 1958 Wolpe pioneered the use of systematic desensitization in the treatment of phobic disorders.⁷ Rachman⁸ and Gelder⁹ reported that desensitization techniques were superior to either individual or group psychotherapy. The most significant new approach to the treatment of agoraphobia was reported by Klein and Fink in 1962.⁹ They pioneered the successful use of anti-depressants in blocking the panic attacks of agoraphobic patients. Later it was demonstrated that the panic could be blocked by pre-treatment with certain anti-depressants in those patients in whom sodium lactate infusion precipitated panic reactions. Zitrin *et al.* describe the effectiveness of imipramine treatment of phobias combined with behavior therapy and/or psychotherapy.¹⁰ The psychotherapy is directed toward helping the patient resolve the anticipatory anxiety (the "what if" symptoms), after the imipramine has effectively reduced or eliminated the panic attacks.

Most psychiatrists and psychopharmacologists who are experienced in the drug treatment of agoraphobia agree that imipramine and phenelzine, a monamine oxidase inhibitor (MAOI), are the most effective treatment agents.¹¹

In my experience, the average daily dose of imipramine for the treatment of agoraphobia is 150mg., although some patients have required as much as 300mg. daily. Klein has reported improvement with daily doses as low as 10 to 25mg. My clinical experience does not support those findings. The initial dose of imipramine is 75 to 100mg. at bedtime and is increased to 150mg. within the first two weeks of treatment. At least a two-week therapeutic lag is noted before the drug controls the phobic symptoms. The dosage may be increased by 50mg. increments at bedtime until symptom relief or side effects intervene. The most frequently reported side effects are orthostatic hypotension and dry mouth. The patient will require some support and encouragement to challenge previously phobic situations.

Phenelzine (Nardil®) is a monamine oxidase inhibitor used in the treatment of depression. It is extremely effective in the treatment of agoraphobia. The average daily dose is from 15mg. three times a day to 90mg. daily. Before treating a patient with Nardil®, the physician must review with the patient the dietary proscriptions for patients on MAOIs. All foods rich in tyramine (pickled herring, liver, aged cheeses, whiskey, beer, ale, wine, and all sympathomimetic drugs) carefully must be avoided. Combination of MAOIs and tyramine may cause hypertensive crises. A list of foods containing tyramine easily may be obtained from the drug manufacturer for distribution to patients.

Most physicians treating phobic patients with drugs agree that the patient should be kept on medication and symptom free for approximately six months. After six months, the dosage should be gradually decreased until the patient is off

"... imipramine and phenelzine, a monamine oxidase inhibitor, (MAOI) are the most effective treatment agents."

medication. Approximately 50 percent of agoraphobic patients will remain symptom free. Others will have to resume taking medication for another six-month period. After one year more than 85 percent of patients treated with drugs will remain symptom free after discontinuation of the drugs. The small remaining group of patients may have to continue on medication for a much longer period of time.

Since both imipramine hydrochloride and phenelzine sulfate are anti-depressant drugs, one might be tempted to speculate that the panic disorders are variants on a depressive spectrum. Sheehan's studies fail to support such an hypothesis.¹¹ He also demonstrated an inverse relationship between chronicity and drug response. The more long lasting the condition, the greater the improvement.

SUMMARY

Agoraphobia, manifested by fear of leaving home and panic attacks, is an extremely common condition. Studies have suggested a possible biological vulnerability and indeed one often is able to elicit a family history of phobic anxiety. The phobic patient develops an extensive avoidance mechanism based on the "what if" syndrome. Most important, these patients, often crippled by their disorders, can be treated rapidly and effectively with imipramine or phenelzine. The treating physician can anticipate a high degree of success. For those few patients who do not tolerate the drugs, combinations of behavioral modification and psychotherapy may prove helpful.

REFERENCES

1. *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. Washington, D.C. American Psychiatric Association, 1980, p 226.
2. *Ibid.* p 226.
3. *Ibid.* p 230.
4. Gelder MG, Marks IM: Desensitization and phobias: A crossover study. *Br J Psychiatry* 114:323-328, 1968.
5. Redlich FC, Freedman DX: *The Theory and Practice of Psychiatry*. New York, Basic Books, 1966, p 367.
6. Pitts FN, McClure JN: Lactate metabolism in anxiety neuroses. *N Engl J Med* 227:1329-1336.
7. Wolpe J: *Psychotherapy by Reciprocal Inhibition*. Stanford, CA, Stanford University Press, 1958, pp 21-44.
8. Rachman S: The treatment of anxiety and phobic reactions by systematic desensitization psychotherapy. *J Abnorm Psychol* 58:259, 1959.
9. Klein DF, Fink M: Psychiatric reaction patterns to imipramine. *Am J Psychiatry*, 119:432-438, 1962.
10. Zitrin J, *et al.*: Behavior therapy, supportive psychotherapy, imipramine and phobias. *Arch Gen Psychiatr*, 35:307-316, 1978.
11. Sheehan DV, Ballenger J, *et al.*: Treatment of endogenous anxiety with phobic, hysterical and hypochondriacal symptoms. *Arch Gen Psychiatr* 37:51-59, 1980.

CASE REPORT

Detorsion of Sigmoid Volvulus by Flexible Fiberoptic Sigmoidoscopy*

FRANCIS W. PREVITI, M.D., Atlantic City
RICHARD W. HOLT, M.D., Washington, D.C.

The initial management of sigmoid volvulus is nonoperative reduction and decompression. A bedside technique employing a 65cm. flexible fiberoptic sigmoidoscope is presented. This procedure requires no sedation or analgesia and may be of benefit even if the torsion is beyond the reach of the rigid sigmoidoscope.

Volvulus of the sigmoid accounts for approximately five to ten percent of all colonic obstructions in the United States.^{1,2} A variety of surgical and nonsurgical procedures has been employed as the initial therapeutic approach to sigmoid volvulus.^{3,4} The types of operative procedures range from simple detorsion to total colectomy depending in part on the presence or absence of gangrene of the colon.

Nonoperative procedures include (1) reduction by rigid sigmoidoscopy with or without rectal tube placement; (2) therapeutic barium or saline enema and, (3) reduction with rectal tube alone. Recent reports have suggested the use of colonoscopy in detorsion of sigmoid colon volvulus.^{5,6}

We wish to report a successful nonsurgical reduction of a sigmoid colon volvulus with a 65cm. flexible fiberoptic sigmoidoscope.

CASE REPORT

A 64-year-old schizophrenic male was admitted to Georgetown University Hospital on April 17, 1979, because of abdominal distention of several days' duration. There had been no bowel movements during this period. There was no nausea, vomiting or fever. Detailed past history was unobtainable.

Vital signs were stable. The abdomen was distended and tympanitic, but the bowel sounds were hypoactive. There was no rebound tenderness. There was no stool in the rectum on digital examination. Plain abdominal roentgenograms

revealed a massively dilated loop of sigmoid colon consistent with sigmoid volvulus.

With the patient in the left lateral decubitus position a 65cm. ACMI (American Cystoscope Makers Inc.) flexible fiberoptic sigmoidoscope was passed to 40cm. At that point, the volvulus detorsed. Large amounts of gas and liquid stool were aspirated via the flexible sigmoidoscope. The instrument was then passed to its full 65cm. extent. All visualized mucosa appeared viable. No analgesia or anesthesia was employed. No enemas were given prior to the procedure. A rectal tube was subsequently inserted. The course after the flexible sigmoidoscopy was uneventful.

A barium enema revealed a huge redundant sigmoid colon. Following mechanical and antibiotic bowel preparation, an uneventful colon resection was performed.

DISCUSSION

Nonoperative detorsion of sigmoid volvulus may be expected to be successful in a high percentage of patients. Drapanas and Stewart reported an 84 percent rate of nonoperative sigmoidoscopic reduction.³ Unsuccessful attempts at nonoperative reduction must be followed by some kind of emergency surgical procedure. The mortality of immediate

*This report is from the Atlantic City Medical Center where Dr. Previti is a member of the surgical staff. Dr. Holt presently is an attending surgeon at Georgetown University Hospital, Washington, D.C. Correspondence may be addressed to Dr. Previti, 16 S. Suffolk Ave., Ventnor, N.J. 08406.

operation for sigmoid volvulus, even without gangrene, is in the range of 15 to 50 percent.⁵ Thus, initial nonoperative management is desirable when feasible.

The 65cm. flexible fiberoptic sigmoidoscope allows for possible detorsion of sigmoid volvulus even when the level of torsion is beyond the reach of the 25cm. rigid sigmoidoscope. A flexible sigmoidoscope may be used at the bedside without sedation or analgesia. Its smaller diameter makes it easier to pass than the conventional colonoscope.

The average age of patients with sigmoid volvulus is over 60 years. Flexible fiberoptic sigmoidoscopy has been shown to be a safe, well tolerated procedure in the older age group.

Flexible fiberoptic sigmoidoscopic detorsion is an additional and perhaps preferable nonoperative technique for reduction of a sigmoid volvulus.

REFERENCES

1. Ottinger LW: *Fundamentals of Colon Surgery*. Boston, Little, Brown, 1974, p. 145.
2. Greenlee HB, Pienbos EJ, Vanderbilt PC, Byrne MD, Mason JH, Banich FE, Freeark RJ: Acute large bowel obstruction. *Arch Surg* 108:47, 1974.
3. Drapanas T, Stewart JD: Acute sigmoid volvulus. *Am J Surg* 101:70, 1961.
4. Arnold GJ, Nance FC: Volvulus of the sigmoid colon. *Ann Surg* 177:527, 1973.
5. Sanner CJ, Saltzman, DA: Detorsion of sigmoid volvulus by colonoscopy. *Gastrointest Endosc* 23:212, 1977.
6. Ghazi A, Shinya H, Wolff WJ: Treatment of volvulus of the colon by colonoscopy. *Ann Surg* 183:163, 1976.
7. Holt RW, Wherry DC: Why flexible fiberoptic sigmoidoscopy is important in the geriatric patient. *Geriatrics* 34:85, 1979.

Nutritional Support of the Hospitalized Patient

MURRAY H. SELTZER, M.D. and
H. STEPHEN FLETCHER, M.D., Livingston*

Satisfactory intravenous or tube feeding is possible for the patient who is unable to consume adequate nutrition. Techniques of nutritional assessment and therapy as well as the potential complications are discussed. Physicians are encouraged to use specialized nutritional support when needed.

America's citizenry and organized medicine consider our population to be among the healthiest and most affluent in the world. For that reason, we find it difficult to believe that malnutrition exists among our hospitalized patients. Bistrian demonstrated protein calorie malnutrition in approximately 50 percent of surgical patients and 44 percent of medical patients in an urban municipal hospital.^{1,2} Physicians now recognize the need to sustain such patients with special nutrients via intravenous solutions and special liquid nutrient diets. This technique is referred to as specialized nutritional support of the hospitalized patient. This article is an overview of contemporary thought regarding these innovations in nutrition for all physicians.

NUTRITIONAL ASSESSMENT

Malnutrition is considered when a hospitalized patient has involuntarily lost greater than ten pounds of body weight in a six to twelve-month period of time. It is also recognized when the serum albumin is less than 3.5 grams/dl and/or when the total lymphocyte count is less than 1500 per cubic mm. Malnutrition is also considered in a patient who has a negative reaction to a series of skin test antigens.

Nutritional assessment of the hospitalized patient usually includes measurement of the body weight and anthropometric measurements including triceps skin-fold thickness to assess body fat and measurement of the mid-upper arm circumference. When the latter is applied to a

mathematical formula, it yields an estimate of lean muscle mass. These values are compared against standard values.

Serum transferrin levels can be extrapolated by applying the formula $0.8 \times \text{the total iron-binding capacity} - 43$. Serum transferrin, having a shorter half life than albumin, is a more accurate early marker of visceral protein loss. Nitrogen balance studies which are of value in assessing the critically ill patient, easily are calculated by measuring the nitrogen intake and subtracting the urine urea nitrogen after adding a factor of four to the urine urea nitrogen. Blackburn has provided a comprehensive description of nutritional assessment.³

There are three primary types of malnutrition encountered in the hospital setting. Protein calorie malnutrition (PCM, marasmus) is applied to those patients with depressed anthropometric measurements who exhibit a satisfactory visceral protein status. Protein malnutrition (kwashiorkor) refers to those patients who have abnormal indices of visceral protein yet may have a normal somatic protein status. Not infrequently, the hospitalized patient exhibits a combination of both protein calorie malnutrition and protein malnutrition as evidenced by abnormal anthropometrics and ab-

*From the Department of Surgery, St. Barnabas Medical Center, Livingston, New Jersey. Dr. Seltzer is Director, Nutrition Support Service and Dr. Fletcher is Co-Director Surgical Intensive Care Unit, St. Barnabas Medical Center, Livingston, New Jersey. Drs. Seltzer and Fletcher also are Clinical Assistant Professors of Surgery, CMDNJ, Newark. Correspondence may be directed to Dr. Seltzer, 22 Old Short Hills Road, Livingston, NJ 07039.

"The albumin level is an indicator of visceral proteins and the absolute lymphocyte count is a "poor man's" marker of immunocompetency."

"The basic tenet of nutritional support is that if the gut works it should be used."

normal visceral proteins.

In an effort to simplify nutritional assessment of the hospitalized patient and to obtain meaningful information immediately upon admission without performing additional diagnostic tests, an instant nutritional assessment of 500 consecutive patients admitted to the St. Barnabas Medical Center was based on serum albumin levels and absolute lymphocyte counts. These tests are readily available. The albumin level is an indicator of visceral proteins and the absolute lymphocyte count is acknowledged as a "poor man's" marker of immunocompetency. When the serum albumin level was less than 3.5 grams/dl, we noted a four times increase in complications ($p < 0.001$) and a six times increase in deaths ($p < 0.025$). When the total lymphocyte count was less than 1500 per cubic mm., a four times increase ($p < 0.05$) in deaths was noted. A more impressive finding was that when the serum albumin and total lymphocyte count were both abnormal, a four times increase in complications ($p < 0.003$) and a 20 times increase in deaths ($p < 0.001$) were noted.⁴

ENERGY REQUIREMENTS

Energy requirements of hospitalized patients vary greatly. For that patient who is at basal rest and does not exhibit serious illness, approximately 1000 to 2000 calories per day will be required to prevent breakdown in body mass. For the patient with moderate activity, fever, surgery or trauma, the caloric requirement will be approximately 2000 to 3000 calories per day. The patient with major trauma, surgery, infection, complications or burns will require greater than 3000 calories per day.⁵⁻⁷

INDICATIONS FOR NUTRITIONAL SUPPORT

In addition to the concept of how to assess the seriously ill patient, one needs guidelines regarding indications for specialized support. The general clinical indications for specialized nutritional support are as follows: 1) hospitalization per se; 2) the inability to eat for five days or longer; 3) an involuntary weight loss of 10 or more pounds; 4) negative nitrogen balance; and 5) evidence of protein depletion. Patients who cannot, should not, or will not eat sufficiently should be assisted. Essentially, any patient whose life is worth saving and who will be unable to consume adequate nutrition for more than five days should be considered for specialized nutritional support.

To replete the nutritionally depleted patient or to prevent such depletion, enteral and parenteral routes of support are available. These two techniques should not be considered mutually exclusive; either one or a combination of both may be necessary to support the hospitalized patient.

ENTERAL NUTRITION

The basic tenet of nutritional support is that if the gut works it should be used. Access to the gastrointestinal tract may be via nasogastric intubation using a Silastic 8 or 9 French feeding tube or using specialized transgastric duodenal tubes. Nasogastric intubation is the most common route used for enteral support, however, cervical esophagostomy, gastrostomy and feeding jejunostomy all should be kept in mind. The advantages of enteral support are: 1) the avoidance of a central venous catheter, 2) introduction of the nutrient material into the portal circulation via the intestine which is essentially a more natural method of nutrient acquisition and 3) a much lower cost than parenteral nutrition. The disadvantages of enteral support are that gastrointestinal disease may be aggravated and both mechanical and secretory activity of the gastrointestinal tract are stimulated with the possible production of diarrhea. In general, it is wise to use formulations that avoid lactose since approximately 70 percent of the world's population are lactase deficient. Enteral feedings are contraindicated in situations where laryngeal or esophagogastric incompetence is demonstrated, where gastrointestinal obstruction or ileus is noted, where high gastrointestinal obstruction or fistulization is present and in those patients who must remain absolutely supine and cannot have their head elevated greater than 10 degrees. This latter group is more vulnerable to the possibility of aspiration.

Selection of nutrients to be used is an important factor in insuring success of therapy. The nutritional adequacy, osmolality and specific disease state of the patient are all important considerations. In general, three types of specialized enteral formulations exist. One of the most complete and authoritative descriptions of these three types of diets can be found in a paper by Shils *et al.*⁸ Tables I (Defined Formula Diets), II (Meal Replacement) and III (Supplements) demonstrate the most salient points of these diets as described by Shils.

The first category, the Defined Formula Diets, is designed to leave minimal residue and lacks fat. The second category, the Meal Replacement, is nutritionally complete. The third category of nutrients is called supplements and is used in addition to food, however, they are not nutritionally complete and vary in their residue and nutrient content. The most effective use of enteral nutrition requires an appropriate feeding route if more than 1,000 calories (1,000 cc) is to be given to a patient in 24 hours. Patients find it extremely difficult to drink more than this quantity in a day. When administered by a feeding tube, it should be administered via a continuous drip over a 24-hour period of time after the position of the tube in the stomach is checked radio-

"The primary indication for parenteral feeding is the unavailability of the gastrointestinal tract to support the patient with an adequate number of calories.

graphically. These materials should not be given in a bolus form; and initially they should be diluted to half strength and the concentration gradually should be increased. The patient should be observed closely for glycosuria and/or diarrhea. It is also appropriate for the stomach to be checked for residual material at intervals during the feeding. The potential complications of enteral feedings relate to regurgitation and possible aspiration, metabolic imbalances such as hyperglycemia, glycosuria and disturbances of serum osmolality, and prerenal azotemia. Fluid and electrolyte balance must be monitored carefully.

PARENTERAL NUTRITION

The renewed interest in nutritional support of the hospitalized patient was stimulated by the dramatic discovery of hyperalimentation in the mid-1960's by Dudrick *et al.*⁹⁻¹³ Today, parenteral nutrition has blossomed into a worldwide method of treatment which is not used frequently enough in many situations where the hospitalized patient is indeed malnourished. The primary indication for parenteral feeding is the unavailability of the gastrointestinal tract to support the patient with an adequate number of calories.

Access to the venous system is a centrally placed catheter, most frequently in the subclavian vein. The internal jugular vein and brachiocephalic system also can be used. Certain treatment modalities may be given peripherally via a vein in any extremity. The most commonly used forms of intravenous nutritional therapy are conventional hyperalimentation, protein sparing therapy, lipid therapy and specific therapy for renal, hepatic and cardiac disease. These methods are not competitive, but have specific indications. The backbone of intravenous nutritional support (hyperalimentation) is a solution containing four to five percent amino acids plus 25 percent glucose, which provides approximately 1000 Kcal. per liter. Appropriate electrolytes, vitamins, and trace minerals are added. Such a solution is used for the patient who is more than minimally ill and who will require intravenous nutritional support for a period of greater than five to seven days. The greatest success to date in restoring a patient's nutritional status has been with these solutions.

To avoid the confusion of many different physicians writing orders for hyperalimentation, we previously standardized our hyperalimentation formula¹⁴ and recently, with a change of product, restandardized our formula. The standardized formula has been so effective that physicians have not found a need to change the basic formula more frequently than 16 percent of the time. Most of the changes are related to potassium concentrations. Standard formulas have enabled physicians to use hyperalimentation more frequently than might have been possible if the orders had to be specifically tailored on a daily basis. Similarly, standard

Table I
Defined Formula Diets

Most Important Properties

- Minimal residue
- Lactase free
- Protein 8 to 16 percent of calories
- Carbohydrate 50 to 90 percent of calories
- Include RDA for vitamins and minerals
- One calorie per cc
- Palatability poor
- Cast - high
- Commercial examples of defined formula diets:
 - Flexical (Mead Johnson)
 - Precision LR (Dayle)
 - Precision HN (Dayle)
 - Vital (Rass)
 - Vivanex (Eaton)
 - Vivanex HN (Eaton)

Table II
Meal Replacement Formulas

Important Properties

- Low residue
- Protein 12 to 16 percent of calories
- Fat 30 percent of calories
- Preferably lactase free
- Include RDA for vitamins and minerals
- Require more complex digestion
- Taste better than defined formula diets
- Lower cost than defined formula diets

Commercial Examples of Meal Replacements

- Camplete B (Dayle)
- Ensure (Ross)
- Ensure Plus (Rass)
- Formula 2 (Cutter)
- Isocal (Mead Johnson)
- Lactene (Dayle)
- Magnacal (Orgonon)
- Nutri-1000 (Cutter)
- Osmolite (Rass)
- Precision Isotonic (Doyle)
- Sustecal Liquid (Mead Johnson)

Table III
Supplements

- Amin-Acid (McGaw)
- High P.E.R. (General Mills)
- Cal-Power (General Mills)
- Cosec (Mead Johnson)
- Cho-Free (Syntex)
- Citroline (Doyle)
- Contralyte (Dayle)
- Gevral (Lederle)
- Hi-Density Nutrient (Cantral)
- Hy-Col (Beecham-Massengill)
- Lipomul (Upjohn)
- Lipa Protein (Upjohn)
- MCT Oil (Mead Johnson)
- Polycose (Rass)
- Pra-Mix (Brunswick Laboratories)

protocols for insertion of a subclavian catheter, for initiation of therapy, and for monitoring of therapy all have been established.

Protein sparing therapy is a term applied to the use of a four or five percent amino acid solution supplemented with electrolytes and vitamins to be used in the absence of carbohydrates. Such therapy may be indicated when there is

a need to provide short-term (7 to 10 days) peripheral nutrition in a patient not seriously ill. This form of therapy is not considered competitive to hyperalimentation. The benefits of this protein-sparing therapy still remain controversial. The philosophy of protein sparing is that avoiding carbohydrates will lower insulin levels and lipolysis of body fat will be enhanced. If body fat can be burned preferentially to protein, one can "spare" protein. Blackburn, a major proponent of protein sparing, has described the technique.¹⁵ A more recent review of the topic is provided by Freeman.¹⁶

The advantages of protein-sparing therapy are that a peripheral route of administration can be used (as opposed to the central route required for hyperalimentation), there is a low incidence of complications and, in many instances, improvement in nitrogen balance can be demonstrated. The disadvantages of protein-sparing therapy are peripheral phlebitis, mild ketosis, possible elevation of blood urea nitrogen and increased cost.

Neither of these two forms of intravenous nutrition support have the capacity to replace fatty acids. It is known that the patient who already is depleted or who will be treated with intravenous nutrition support fluids for a period of two to four weeks may develop fatty acid deficiency. Fats as a caloric source have become available in the United States within the past few years. Two products currently available provide 10 percent fat emulsion solutions in either soybean (Intralipid®) or sunflower oil (Liposyn®) for use as a caloric source. These materials can prevent or correct fatty acid deficiencies and may be given in conjunction with hyperalimentation or as a separate nutrient support system via a peripheral vein consisting of amino acids and glucose (10 percent) in one bottle with the fat being administered in another. The limitation of this system is that usually not more than 1800 calories can be administered within a 24-hour period. An excellent description of its usage is provided by Silberman.¹⁷

At the current time, a renal failure solution known as Nephramine® consisting of 1.5 grams of nitrogen is available to be mixed with 70 percent dextrose yielding 750 cc. of a solution providing 1250 kilocalories for the renal failure patient. Such a solution has proved extraordinarily useful both in acute and chronic renal failure patients. Renal failure solutions have been described in the literature.^{18,19}

Branched chain amino acid solutions for hepatic failure and the use of specialized materials for cardiac failure patients currently are coming into usage, however, they are not available on a wide scale basis at the present time.²⁰⁻²²

It is important that appropriate vitamins be added to the intravenous material. At the present M.V.I.® is the material most frequently used because it contains fat soluble and water soluble vitamins. There has been great controversy related to the appropriate quantity of vitamins with very few well-done studies addressed to this point.²³

Trace minerals are important and deficiencies can occur. A recent publication by a consensus committee has aided in the establishment of guidelines for the use of trace minerals.²⁴

The use of filters has been a controversial one. At present, there is no conclusive evidence for or against their use. We do not use filters at Saint Barnabas Medical Center routinely. Pumps can be of great value in regulating the flow rates of intravenous and enteral products and rarely have a negative effect on patient therapy. Despite the advantage of the pump to both intravenous and enteral therapy, they can be accomplished satisfactorily without the use of pumps. It is not advisable to regionalize patients within a hospital receiving

"Complications of therapy are either mechanical, septic or metabolic."

intravenous nutritional support since the illnesses requiring such support cut across almost every specialty in medicine.

Subclavian catheterization has been an area of concern, but an experienced physician can do the procedure with a minimum of complications. The end objective is to insert a catheter into the superior vena cava, but not into the right atrium, so that highly concentrated materials can be delivered into a high venous flow system. A detailed description of the correct insertion of a subclavian catheter has been described elsewhere.^{25,26}

COMPLICATIONS

Complications of therapy are either mechanical, septic or metabolic. Mechanical complications primarily relate to accidents of insertion of a subclavian catheter resulting in injury to the pleura, lung, associated blood vessels or nerves. These can be minimized by careful insertion of subclavian catheters.

Sepsis, associated with intravenous nutritional support has been greatly decreased because of meticulous attention to dressing changes and to the preparation of solutions. Preferably, only one person should change all dressings and solutions can be prepared only in a pharmacy with a laminar air flow hood.

Metabolic complications are well documented in the medical literature and primarily depend upon the diligence with which the physician closely watches patients being treated with hyperalimentation. Even with close supervision, such complications can occur. One must watch for glucose intolerance, hyperosmolarity, electrolyte imbalance, vitamin, trace metal and fatty acid deficiencies.

NUTRITION SUPPORT TEAM

With the rapid growth and development of specialized nutritional support and where no specific medical specialty devoted to this treatment exists, it becomes the responsibility of all practicing physicians to evaluate carefully patients in need of such support. Many hospitals have found it advantageous, as we have at the Saint Barnabas Medical Center, to organize a nutrition support team consisting of physician, pharmacist, nurse, dietitian and other interested parties to facilitate proper patient care, efficiency as well as economy.

The American Society for Parenteral and Enteral Nutrition (ASPEN)²⁷ was founded in 1975 to convey information regarding parenteral and enteral nutrition to health care professionals via clinical meetings and publications of a journal, a newsletter and monographs. The demand for such information has boosted the membership rolls of this organization to over 3,000 members at the present time.

†U.S.V. Laboratories, Tuckahoe, NY

²⁷1025 Vermont Avenue, N.W., Suite 810, Washington, DC 20005

Finally, there are a few noteworthy texts dealing with specialized nutritional support as well as general aspects of nutrition. The reader is referred to them.²⁷⁻³²

CONCLUSION

The advent of specialized nutritional support and more specifically hyperalimentation has improved radically the physician's ability to care for malnourished patients. The development of these treatment modalities rank in magnitude with the development of antiseptics, anesthesia and antibiotics. They will continue to play an expanding role in patient care as new materials are developed.

REFERENCE LIST

1. Bistrian BR, Blackburn GL, Hallowell E, *et al*: Protein status of general surgical patients. *JAMA* 230: 858-860, 1974.
2. Bistrian BR, Blackburn GL, Vitale JJ, *et al*: Prevalence of malnutrition in general medical patients. *JAMA* 235:1567-1570, 1976.
3. Blackburn GL, Bistrian BR, Maini BS, *et al*: Nutritional and metabolic assessment of the hospitalized patient. *J Parent & Ent Nutr (JPEN)* 1:11-22, 1977.
4. Seltzer MH, Bastidas JA, Cooper DM, *et al*: Instant nutritional assessment. *J Parent & Ent Nutr (JPEN)* 3:157-159, 1979.
5. Kinney JM: Energy requirements for parenteral nutrition, in Fischer JE (ed): *Total Parenteral Nutrition*, Little, Brown & Co., Boston, 1976, pp. 136-142.
6. Kinney JM, *et al*: Tissue composition of weight loss in surgical patients. I. Elective operation. *Ann Surg* 168:459, 1968.
7. Dudrick SJ and Rhoads JE: Total intravenous feeding. *Scientific American* 226:3-10, 1972.
8. Shils ME, Bloch AS, Chernoff R: Liquid formulas for oral and tube feeding. *Clin Bull* 6:151-158, 1976.
9. Dudrick SJ, Wilmore DW, Vars HM, *et al*: Long-term parenteral nutrition with growth, development and positive nitrogen balance. *Surgery* 64:134-142, 1968.
10. Wilmore DW and Dudrick SJ: Growth and development of an infant receiving all nutrients exclusively by vein. *JAMA* 203:860, 1968.
11. Dudrick SJ, Wilmore DW, Vars HM, Rhoads JE: Can intravenous feeding as the sole means of nutrition support growth in the child and restore weight loss in an adult? *Ann Surg* 169:974-984, 1969.
12. Dudrick SJ and Rhoads JE: New horizons for intravenous feeding. *JAMA* 215:939-949, 1971.

13. Dudrick SJ: The genesis of intravenous hyperalimentation. *J Parent & Ent Nutr (JPEN)* 1:23-29, 1977.
14. Seltzer MH, Asaadi M, Coco A, *et al*: The use of a simplified, standardized hyperalimentation formula. *J Parent & Ent Nutr (JPEN)* 2:28-30, 1978.
15. Blackburn GL, Flatt JP, Clowes GHA, O'Donnell TE: Peripheral intravenous feeding with isotonic amino acid solutions. *Am J Surg* 125:447-454, 1973.
16. Freeman JB, Stegink LD, Wittine MF, Thompson RG: The current status of protein sparing. *Surg Gynec & Obstet* 144:843-849, 1977.
17. Silberman H, Freehauf M, Fong G, Rosenblatt N: Parenteral nutrition with lipids. *JAMA* 238:1380-1382, 1977.
18. Dudrick SJ, Steiger E, Long JM: Renal failure in surgical patients: Treatment with intravenous essential amino acids and hypertonic glucose. *Surgery* 68:180-186, 1970.
19. Abel RM, Beck CH, Abbott WM, *et al*: Improved survival from acute renal failure after treatment with intravenous essential L-amino acids and glucose. *N Engl J Med* 288:695-699, 1973.
20. Blackburn GL, Moldawer LL, Usui S, *et al*: Branched chain amino acid administration and metabolism during starvation, injury and infection. *Surg* 86:307-315, 1979.
21. Freund H, Hoover HD Jr, Atamian S, Fischer JE: Infusion of the branched chain amino acids in postoperative patients. *Ann Surg* 190:18-23, 1979.
22. Freund H, Yoshimura N, Fischer JE: Chronic hepatic encephalopathy. *JAMA* 242:347-349, 1979.
23. Nichoads G, Meng HC, Caldwell MD: Vitamin requirements in patients receiving total parenteral nutrition. *Arch Surg* 112:1061-1064, 1977.
24. Shils ME, Burke AW, Greene HL, *et al*: Guidelines for essential trace element preparations for parenteral use. *JAMA* 241:2051-2054, 1979.
25. Asaadi M, Seltzer MH: Subclavian intravenous catheterization for hyperalimentation. *Resident & Staff Physician* 26:53-58, 1980.
26. Taylor JK: Parenteral nutrition by subclavian vein. *Hospital Physician* 78-83, November, 1970.
27. Fischer JE, ed: *Total Parenteral Nutrition*. Boston, Little, Brown, 1976.
28. Wilmore DW: *The Metabolic Management of the Critically Ill*. New York, Plenum, 1977.
29. Grant JP: *Handbook of Total Parenteral Nutrition*. Philadelphia, Saunders, 1980.
30. Ballinger WF, *et al*, eds: *Manual of Surgical Nutrition (American College of Surgeons)*. Philadelphia, Saunders, 1975.
31. Burton BT: *Human Nutrition*. New York, McGraw-Hill, 1976.
32. Halpern SL: *Quick Reference to Clinical Nutrition*. Philadelphia, J.B. Lippincott, 1979.

Edward Miller— American Physician (1760-1812)

FRANCIS P. CHINARD, M.D., Newark

Educated by local physicians, Miller received his M.D. degree from the University of Pennsylvania, where he became a friend of Benjamin Rush. He practiced in Delaware and Maryland and in New York City at the time of yellow fever epidemics. His views on medicine and medical education in many respects are consonant with those with which we are familiar. His career could serve as a paradigm for the concerned physician.

When a former chairman of a department of medicine tells us of his travails as a medical student during the four years following his retirement from the chairmanship, we must listen and pay heed. Eichna, the survivor of this experiment, concisely expressed his concern that principles of medical school education that are generally accepted are just as generally violated.¹ He also voiced the hope that improvements can be made in educational content as well as in patient care by "producing good doctors who are scientifically and clinically able, and who serve patients ethically."¹ These have been the aims of medical schools not only of these but also of earlier times.

Curricular and educational concerns which are not unique to our period seem to be particularly evident when criticism of and dissatisfaction with the medical profession exhibit an increase, an event which occurs at times when substantial scientific and technical advances are in progress. The period at the beginning of the American Revolution in 1776 to the end of the Napoleonic era in 1815 was one of tremendous scientific activity as well as of cultural, economic and military change.

Occasionally, it serves to review the events and the environment that some of the less flamboyant, less dramatic and less well known have experienced and participated in and to see what perspectives such reviews may shed on our own problems and predicaments. To that end I present briefly the career and some of the philosophical ideas of one

Edward Miller, late Professor of the Practice of Physic in the University of New York and Resident Physician for the City of New York, a possible paradigm for Dr. Eichna's desiderata.

My major source is a volume published by Samuel Miller, Edward's brother and Professor of Ecclesiastical History and Church Government at the Theological Seminary in Princeton.² It contains the major medical works of Miller and a biographical sketch.

Edward Miller was born on May 9, 1760, in Dover, Delaware. His mother, Margaret Millington, was from Talbot County in Maryland and his father, John Miller, was Pastor of the Presbyterian Church in Dover for 43 years. Edward was the third of four sons, the firstborn of whom, John Miller, was a physician. John Miller joined the American Army in 1776 as a volunteer surgeon and died in 1777 at the age of 25. There were also two sisters.

Until the age of 14 Edward Miller's education was provided by his father, an excellent Greek, Latin and Hebrew scholar. He then was sent to a seminary in the village of Newark, Delaware, where he pursued classical studies in Latin and Greek with readings in the arts and sciences. His academic course completed in 1778, Miller began the study

*Read before the first meeting of the Medical History Society of New Jersey, October 8, 1980, Rutgers Medical School, Piscataway. Dr. Chinard is affiliated with the Department of Medicine, New Jersey Medical School, CMDNJ, Newark. He may be addressed at the School, 100 Bergen Street, Newark, N.J. 07103.

of medicine under Charles Ridgely, a physician of Dover. He pursued these studies for two years and in 1780 he received in appointment as surgeon's mate in the army. Most of his time was spent at a hospital in Basking Ridge. Then, in 1781, he accepted the position of Surgeon on "an armed ship bound for Europe." He learned French, acquainted himself with the state of the arts of Medicine there and acquired a substantial collection of medical books.

On his return in 1782 he followed a series of medical lectures at the University of Pennsylvania. It was then he met Benjamin Rush and from that meeting there developed an "intricate and endearing friendship." Here, his professional knowledge was greatly expanded. As his brother put it: "for while he observed and thought for himself and always attached much importance to experience in medicine; he, at the same time, had a deep impression of the value of able instructors, and well constituted Medical Schools."

The treaty of 1783 led to his severing connections with the armed services and in 1784 he began to practice in Frederica, a small town about ten miles south of Dover. However, a short trial there was unsatisfactory and he soon migrated to Somerset County on the Eastern Shore of Maryland where for two years he enjoyed the benefits of an affluent and cultured neighborhood and of a lucrative practice.

Family pulls were strong and with the death of his first medical preceptor, Dr. Ridgely, he returned to Dover where he settled down for a number of years. He visited Philadelphia at least once a year and thus kept in touch with his many past colleagues and with medical progress.

DOCTOR OF MEDICINE

It was in 1789 that he was awarded the degree of Doctor of Medicine by the University of Pennsylvania on the basis of his dissertation, written in Latin, "De Physconia Splenica" or splenic swelling, a problem frequently encountered in Delaware with remittent and intermittent fevers. (Physconia intent was to develop legislation that would provide access to bellad, a term earlier on applied to Ptolemy II). Miller joined the Medical Society of Delaware and participated actively in its deliberations.

This pleasant life was interrupted in 1796 when pressures from his brother led him to move to New York to help fill the gaps left by death of many physicians who were victims of what was called "yellow fever." He readily gained acceptance in New York and joined the Friendly Club, a discussion group which numbered lawyers, physicians, clergymen among its members. More important to medicine was Miller's enrollment in 1796 in the founding of the *Medical Repository*, a periodical dedicated to the publication of facts "free from the incumbrance of systematized hypothesis . . . the surest guides amidst the intricacies of practice." The contents were to include: (1) histories of such diseases as occurred in particular places in human beings, (2) similar accounts of diseases among animals, (3) accounts of insects, (4) progress and condition of vegetation and (5) accounts of the state of the atmosphere.

A yearly publication of such information would allow one to perceive "what diseases prevailed at the same time, in all the intermediate situations, from St. Mary's to St. Croix, and from the Mississippi to the Atlantic." Other contents would include: (1) case histories (2) occupational diseases (3) new therapies (4) information on minerals, plants and animals (5) American medical biography (6) accounts of former American medical publications (7) reviews of new American medical publications and (8) medical news.

All of this is suggestive of the contents of some current medical weeklies. The impact of the *Medical Repository* was considerable. It encouraged free inquiry and the abandonment "of prejudices and errors of the European Schools."

Miller was also a member of the American Mineralogical Society which provided opportunities for the promotion of science and the fostering of interest in the development of the mineral resources of this country.

THE YELLOW FEVER EPIDEMIC

One of the greatest medical challenges that Miller met was the Yellow Fever epidemic of 1798. Here I will quote from his brother's biography:

"The malignant and fatal epidemic of 1798 is but too well recollected by every adult inhabitant of New York. Doctor Miller had then been residing two years in the city; and he found his medical practice considerably increased. As he believed the Yellow Fever to be neither imported nor contagious, and as his residence was in the most healthy street in the city, he early resolved to commit himself to the care of Providence, and to remain at this post. He did so and was mercifully preserved. The writer of this sketch (Dr. Miller's brother) also remained in the city, during that melancholy season, and spent the whole of it under the same roof with his Brother; and never shall he forget either, on the one hand, the persevering and almost incredible labours of that beloved Relative; or, on the other, the gloom and horror of the general scene. Dr. Miller visited all who sent for him, without discrimination or reserve. The rich, who were able to remunerate him, had chiefly left the city; his professional labours were in a great measure devoted to the poor and forsaken, from whom no recompense could be expected. Yet he attended them with unceasing assiduity; though he often exhibited such marks of fatigue, exhaustion, and mental depression on account of the scenes through which he passed, as could not have been described, or easily conceived, without personally witnessing them."

Because of the recurring epidemics of that period, the New York State legislature passed an act which was designed to provide for the recognition of such epidemics and for the adoption of measures for their control. Three positions were created, one of these being that of Resident Physician of New York to which Miller was appointed in 1803. Except for an interlude of one year, he held that post until his death.

In 1806, Miller wrote a fascinating account of yellow fever in which he concluded that the cause of the disease was a pernicious exhalation or vapour floating in the atmosphere, and that it was clearly not contagious. Among his recommendations, which were entirely concerned with sanitation, he urged the "draining of all stagnant waters in the town and neighborhood and the filling up, levelling and paving all low and depressed lots and places." The more clinical aspects were discussed in an article "Cursory Observations on that Form of Pestilence called Yellow Fever." Treatments recommended included blood-letting "which will stand first on the list of remedies to be employed to diminish its violence. It is admitted, at the same time, that the use of this evacuation, especially in the more malignant and prostrating forms of the disease, will require the greatest caution and discernment. But, to deny altogether the admissibility of blood letting . . . is, in my judgment, to oppose some of the most established maxims in the practise of medicine" But further, we read: " . . . where a large dose of miasmata has been received into the system . . . every hope of relief from this remedy will ultimately fail." There is some ambivalence here which might

have stemmed from Miller's desire not to upset his Philadelphia colleague who believed so blindly in the efficacy of blood-letting in the treatment of yellow fever.

In 1807, with the creation of the College of Physicians, in part for the promotion of professional education, Miller became the incumbent of the chair of Professor of Physic and embarked on a series of lectures on medical topics which appear to have been quite well received. Two years later he was appointed to the staff of the New York Hospital and subsequently received the title of Clinical Lecturer. A comment from one of his friends indicates that he combined sympathy for the sick with regard for the well.

Miller had many correspondents in this country and abroad and received wide recognition. In 1805, he was elected to membership in the American Philosophical Society. The high regard in which he was held clearly is indicated in the many letters to his brother and the testimonials, including one from Rush, which followed Edward Miller's untimely death in 1812 at the age of 52.

From these we can glean some information about Miller's personality and character. "He did not feel a pulse and look at a tongue, with the affected gravity of sage stoicism, then write a prescription, and hurry to the next patient upon the list; but he tenderly inquired and anxiously sought for the seat and source of pain, and while his dignified deportment and easy manners conciliated the mind of the sufferer, the interest he so obviously took, inspired confidence, and tended more to restore hope and health, than even the medicine his experience recommended."

His personal habits were exemplary. Neat in dress, pure of mind and of speech, he scrupulously avoided ardent spirits and only occasionally indulged in wine. He avoided tobacco in every form, believing that its use could lead to drinking. He also avoided indulgences of the palate. He was reserved with those he did not know and perhaps shy. He never married. His domestic circle was limited to his brother, his sisters and their families. This ascetic Dr. Miller does appear to have had one redeeming vice; he may have been messy: "his apartments were ornamented by the indications of his pursuits; every table and sofa displaying manuscripts, pamphlets and volumes, collected by his industry, or flowing as tributes to his talents."

Among Miller's scientific works there were some unfinished manuscripts. One, for example, is "On the Influence of Temperature on Health and National Character." Another is on "The Certainty of Medicine" in which he castigates the use of the fallacious rule of "post hoc propter hoc" as a basis for inclusion of specifics in the *Materia Medica*. Here, he also carefully analyzes the laws of medical evidence.

"When a man asserts he has been cured of a particular disease by a certain remedy, he is apt to think he is declaring a fact, which, as coming under his own observation, and experienced in his own person, he knows to be undeniably true; whereas, this assertion, simple and unequivocal as it may appear at first sight, includes two opinions, in both of which he may be completely mistaken. The first is an opinion of his having had the disease specified; the second, that the medicine employed removed the disease."

MILLER AND MEDICAL EDUCATION

Miller also wrote on topics such as sea-sickness, infant cholera and cutaneous perspiration but it is to his thoughts on medical education that I would now turn.

Miller was not a medical educator in the sense of the term as it is too frequently used today, that is a maker of

schedules, a master of committees and a developer of curricular programs. Nonetheless, he had interesting ideas on what medical education could be; his ideas are not alien to some current ones.

According to Miller, the system of instruction ought to embrace five principal subjects:

1. Knowledge of animal economy, acquired by the study of anatomy, chemistry and physiology, or the science of man in the state of health.
2. *Materia Medica*, chemistry and pharmacy.
3. "Knowledge of the rules and means most conducive to the preservation of the body in a state of health."
4. Knowledge of the various diseases incidental to the human body, their nature, causes, symptoms and the appropriate remedies; thus, therapeutics and clinical medicine and surgery.
5. "The history of Medicine and Surgery, and the best manner of studying these sciences. By this, a complete view of the subject, in its whole extent, will be exhibited. What has been already done by our venerable predecessors, and what remains to be accomplished will be distinctly seen."

Miller lists the various subjects of instructions with commentaries as to how they might best be presented. Thus, "anatomy may be separated from physiology; but physiology cannot so properly be taught by itself; it is most conveniently conjoined with the study of the human body." And, later "the plan for conducting medical studies cannot be pointed out by any teacher with more advantage, than by the professor of the history of medicine, who must necessarily have occasion, every day, to mark the succession and to appreciate the value of publications intended to advance the progress of medical science. The history of medicine and surgery is one of the most profound and philosophical (subjects), and at the same time, one of the most interesting that can engage the consideration of students."

Despite this overt enthusiasm, Miller recognized practical limitations to his scheme. "While we admit that it is too complicated, too unwieldy and too expensive for this country, in its present state, we cannot forbear hoping that the time will arrive when we shall be able to make a clearer approximation to it. A course of lectures on the history of Medicine, and on the plans for conducting medical study and observation, though these subjects do not certainly rank among those which are of primary and fundamental importance to the student, ought undoubtedly to be reckoned among such as are the most arduous, the most learned and the most useful in the whole system."

Miller cited with apparent approval the course of study proposed by, among others, Debboes in England with its emphasis of clinical experience and also the recommendations of Van Swieten in Vienna and of Tissot, both of whom gave full support to the inclusion of the history of medicine in the later years of the curriculum.

Somewhat similar, but much more systematized ideas, which may have influenced Miller, were in fact put forth in France in 1791 in a report on universal education prepared by the one-time Prince, then Bishop and at the time President of the National Assembly, Charles Maurice de Talleyrand-Perigord. Talleyrand was a brilliant, amoral, unscrupulous turncoat politician who, during his career, managed to work for three kings, a republic and an empire without losing his head. The report was on public education and part of its intent was to develop legislation that would provide access to knowledge and to the professions for all.³ In brief, it was a plan for universal instruction for both sexes, for all ages. For

medicine, to which surgery was joined, a national organization was essential for it was recognized (even then) as one of the disciplines the practice of which requires a long educational period and in which errors could be disastrous for society. Hence, the report recommended the creation of National Institutes to be established in the capital, Paris, for the teaching and expansion of knowledge in all fields.

Talleyrand's report advocated combining into single institutions, medicine, surgery and pharmacy. Teaching must include (1) the physical manifestations of disease, (2) analysis or knowledge of all substances—mineral, vegetable or a minimal of use or concern in medicine, (3) study of the human body in health, (4) the study of diseases with respect to symptoms, means of observation and of determining their natural history and their management, (5) the necessary data to be in the position to enlighten those making decisions about the life and honor of citizens and (6) the study of the practice of medicine. The courses to be given included:

(1) Physical manifestation of disease, hygiene or public health, (2) Anatomy, (3) Physiology, (4) Chemistry, (5) Pharmacy, (6) Botany and materia medica, (7) Pathology, nosology, semiotics and therapeutics, (8) History and art of medicine, and legal medicine, (9) Practice of the medicine of internal and external diseases, partly at bedside, (10) Theory and practice of obstetrics.

Proficiency in these various subjects was to be tested by written and oral examinations. However, the emphasis on the clinical abilities is evident in the absence of a requirement of attendance at lectures and the absolute requirement of assessment of clinical proficiency at the bedside of patients.

Apart from the much more extensive content which our students have to contend with nowadays, this curriculum, which included emergency and occupational medicine, differs little from the one we provide today. Basic sciences are required with emphasis on clinical proficiency but the History of Medicine was also included. All fields of learning were encompassed in this grand design; the part on medical education was largely based on the proposal made by Vicq d'Azyr, the physician of Marie Antoinette, a year or so earlier on behalf of the French Royal Society of Medicine.⁴ Also be it noted that, in one of the tables in the Talleyrand report there is a comment on the usefulness of having physicians in academic positions travel widely. We may be following this admonition today only too well.

In summary, although the content of medical education has changed dramatically in 200 years, the container remains much the same.

MILLER'S CONTEMPORARIES

Where does Miller stand in relationship to his contemporaries? Clearly he was recognized for his talents and even Rush contributed an effusive outpouring of emotion and praise at the time of Miller's death. But, it is curious that little mention has been made of Miller by biographers of Rush. In his annotations of Rush's autobiography, Corner mentions Miller in a footnote as editor of the *Medical Repository* and as a warm friend of Rush but no more.⁵ Goodman's biography cites a letter from Miller to Rush in 1802 in which the non-contagiousness of yellow fever is mentioned.⁶ Miller has not become a familiar name in our historical consciousness probably because he was one of the unimportant essentials who did his job as he saw it, carried huge responsibilities effectively and left the center of the stage to those whose temperament and ambitions were more suited to such performance. Clearly, Miller as a physician did

far less harm to his patients than the fictional Dr. Sangrado portrayed by LeSage in 1715 in his "Gil Blas"—a physician who emphatically believed in bleeding his patients whatever the problem and who did much more damage than the epidemics he was attempting to treat. Miller's "warm friend" and occasional mentor, Rush, probably shed enough blood in and about Philadelphia to float if not a ship of the line at least a small barque.

It is appropriate to conclude with yet another quotation from Miller's lecture on medical education which epitomizes his goals and his perspective.

"The true end of science is the production of new powers, and the application of them to the greatest possible variety of useful purposes. The votaries of medicine then should never be idle, nor weary in the pursuit of discovery and improvement; for industry or accident may eventually teach them to subdue maladies which now elude every exertion of art. There was a period when ague and syphilis were considered as incurable. The antidote to both is now well known. It is not presumptuous to believe that nature, in the fullness of her beneficence, holds a remedy for every evil by which we are assailed. The period we trust is not remote when the means of arresting the ravages of pestilence and consumption will be placed among the trophies of medical discovery."

SUMMARY

Edward Miller was born in Dover, Delaware in 1760. He studied medicine under local practitioners and joined the army as surgeon's mate in 1780. After a trip to Europe in 1781 and after several years of practice in Maryland and Delaware he received his M.D. from the University of Pennsylvania in 1789. In Philadelphia, he became a friend of Benjamin Rush. In 1796, he moved to New York City where he became heavily involved with the yellow fever epidemics which periodically devastated the area. He was less enthusiastic than Rush about the virtues of bleeding in that disorder. Miller wrote on a variety of subjects, including "Certainty in Medicine" and medical education. His views on the latter would, on the main, be considered unexceptional today: emphasis of anatomy, chemistry, physiology as preparations for the clinical years, hygiene or public health, medicine and surgery should be closely integrated and "man in a state of disease" should be the basis for the clinical studies. A focal role was to be played by the "history of medicine," the professor of which "must necessarily have occasion, every day to appreciate the value of publications intended to advance the progress of medical science."

Dr. Miller's career and life are reviewed briefly and some of the curricular proposals of others of the period (Beddoes, Van Swieten, Talleyrand) and their similarities to Miller's are indicated.

REFERENCES

1. Eichna LW: Medical school education 1975-1979. A student's perspective. *N Engl J Med* 303:727-734, 1980.
2. Miller S: *The Medical Works of Edward Miller, M.D.* New York, Collins, 1814.
3. Talleyrand-Perigord CM de: *De l'Instruction Publique*. Paris, Assemblée Nationale, 1791.
4. Courcy C: *L'Enseignement de la Médecine en France*. Paris, L'Expansion Scientifique Française, 1968.
5. Corner GW: *The Autobiography of Benjamin Rush*. Princeton, Princeton University Press, 1948.
6. Goodman N: *Benjamin Rush. Physician and Citizen*. Philadelphia, University of Pennsylvania Press, 1934.

New Concepts in Nutrition and Cancer: Implications for Folic Acid*

C. E. BUTTERWORTH, JR., M.D., Birmingham, Alabama

A great deal of interest has developed in the subject of nutrition and cancer in recent years both on the part of the general public and professional scientists. Indeed, *Nutrition and Cancer*, an international journal, has been established to deal exclusively with the subject and has been available since 1979.

It now generally is recognized that cancer is not one disease, but a complex array of disorders with widely varying etiologies and treatments. In view of the known complexities and broad scope of nutrition sciences, it would seem an almost hopeless task to find meaningful interrelationships between the two topics! Yet, some order appears to be emerging from the seeming chaos of this unwieldy pair of topics.

MECHANISMS BY WHICH DIET AND NUTRITION MAY BE RELATED TO THE ETIOLOGY OF CANCER

It will not be possible, due to limitations of space, to discuss all of the possible mechanisms by which diet and nutrition may be related to the etiology of cancer. Some of them are presented in Table 1.

Table 1

1. Carcinogens (and pro-carcinogens) in food,
2. Oxidant damage to cells; lack of antioxidant substances in the diet,
3. Excessive intake of certain nutrients (e.g., animal fat, selenium, iron, alcohol, vitamin A),
4. Altered solubility, adsorption, absorption of nutrients and/or carcinogens due to dietary factors (e.g., fiber),
5. Altered enteric bacterial population due to dietary factors,
6. Chromosome damage due to nutrient deficiency,
7. Abnormal repair of chromosome damage,
8. Altered metabolism of hormones (e.g., in obesity),
9. Impaired immunity to tumor cells and viruses, and
10. Genetic "susceptibility" plus dietary factors.

It may be seen that some of the mechanisms are not strictly independent. Many seem to share, as a common denominator, some sort of genetic or chromosomal injury which may, in turn, be conditioned by nutritional factors. For example, healthy immune systems are thought to be capable of recognizing and destroying certain deviant cells which might arise from a chemical or viral mutagen. In other situations, chromosome damage could occur as a result of either primary nutritional inadequacy or an abnormal repair mechanism. It has, moreover, been known for many years that certain tumors are hormone dependent and it is well known that the action of hormones and nutrients are intricately intertwined.

Three new concepts seem to be emerging which have great promise for understanding relationships between nutrition and cancer; these are: (1) the concept of hormonally induced *localized nutrient deficiency*, (2) the concept of nutritionally dependent, *fragile sites on human chromosomes*, and (3) the concept of altered pathways of nutrient metabolism induced by oncogenic viruses. Since these seem to be unifying concepts which are likely to have considerable influence on future research, they merit careful study. The following paragraphs are offered as a brief, general introduction to the subject.

CONCEPT OF LOCALIZED NUTRIENT DEFICIENCY

It has been traditional to think of nutrient requirements in terms of the whole organism and relatively little attention has been paid to the requirements of individualized tissues. Of course, the importance of nutrient requirements during pregnancy, infancy, lactation and even in response to trauma have been recognized. However, the role of nutrients in the maintenance of structure and function in individual tissues has received scant attention. Moreover, it has been tacitly assumed that the nutrient content of a tissue is somehow a constant property related in some way to its structure and function. But, relatively little is known about the dynamic changes that may occur normally in either animal or human tissues over short periods of time.

It seems important now to consider the *fluctuations* that may occur in nutrient content of tissue as the result of intake patterns, hormonal stimulation and various patterns, and various other stresses. Folic acid may be regarded as a model nutrient to illustrate some of these concepts.

It has been known for many years that folic acid plays a key role in the expression of steroid hormone effects on target tissue.^{1,3} For example, when chicks and monkeys are grown on a folic acid-deficient diet, the female genital tract fails to develop normally in response to estrogen stimulation. In 1973, Whitehead *et al.*⁴ observed megaloblastic features in cervical epithelial cells from a group of women who were using steroid hormones as oral contraceptive agents (OCAs). Although the cytologic changes were not associated with evidence of systemic vitamin deficiency, they disappeared with oral folate supplementation, leading the authors to

*Reprinted with permission of Contemporary Nutrition 5:12 (Dec) 1980, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Butterworth is Professor and Chairman of the Department of Nutrition Sciences, University of Alabama, Birmingham.

postulate the existence of *localized* folate deficiency in the cervix.

Subsequently, Krumdieck *et al.*⁵ demonstrated in laboratory tests that cyclic variations normally occur in the content and nature of folate coenzymes in the rat uterus during successive stages of the reproductive cycle. During proestrus the activity of the enzyme pteroyl polyglutamyl hydrolase ("conjugase") doubled, and the total folate content was nearly doubled. There was a relative decline in the polyglutamate form and an increase in the coenzymes having a shorter chain length. These changes were interpreted as being associated with the cyclic "burst" of mitotic activity needed to regenerate the endometrium in preparation for possible implantation of fertilized ova during the subsequent stage of estrus. In this connection, it is of interest to note that the risk of developing endometrial cancer is increased 4-fold to 15-fold in women who have been long-term users of estrogens.⁶ It is also of interest that many papers have called attention to the association of obesity with endometrial cancer. It also has been shown⁷ that there is an increased conversion of a naturally occurring androgen to an estrogen in obese subjects. Thus, individual differences in hormone metabolism could affect the nutrient content of specific tissues. In 1976, a clinical trial began to test the hypothesis that cervical dysplasia is associated with localized folacin deficiency and that the deficiency can be corrected by an oral supplement of the vitamin.

Forty-seven young women with mild or moderate dysplasia have now received oral supplements of either folic acid, 10 mg daily, or a placebo, under strict double-blind conditions for three months while continuing their established use of a combination-type OCA.^{8,9} There was significant improvement in the final cytology scores of the supplemented subjects, whereas the placebo group showed no change. In addition, biopsies obtained under colposcopic guidance were significantly better among supplemented than unsupplemented subjects. There were four cases of apparent regression to normal among subjects receiving folic acid supplementation, but none in the unsupplemented group. There were four cases of apparent progression to carcinoma *in situ* among the unsupplemented subjects, but none in the group receiving folic acid supplementation. The data are interpreted as indicating that oral folate supplementation may prevent the progression of early cancer to a more severe form and in some cases promote reversion to normalcy.

CONCEPT OF FRAGILE SITES AND SOMATIC MUTATIONS

It recently has been demonstrated that human chromosomes tend to break at certain specific locations under certain specific conditions and that the tendency is a heritable trait demonstrable in family pedigrees. In a recent series of papers, Sutherland¹⁰⁻¹² has described the occurrence of fragile sites in at least seven different human chromosomes in lymphocytes and fibroblasts grown under chemically defined conditions. Manifestations of fragile sites include nonstaining gaps at exactly the same point on a given chromosome, acentric fragments, deleted chromosome, sister chromatid exchange and related phenomena. It seems highly significant that the nutrient content of the culture medium is a key factor in demonstrating the presence of a fragile site. Many of them can be demonstrated by growing in tissue culture medium that is relatively deficient in folic acid. Expression of the phenomenon can be blocked by providing an excess of folic acid, citrovorum factor or thymidine in the medium.

So far, there is no clear evidence that fragile sites are involved in cancer formation in humans or animals. However, their existence offers a mechanism whereby specific mutations could occur in target tissue if folic acid or some other essential nutrient is in relatively short supply. In addition, they would help explain how a family tendency toward cancer could exist in a dormant state until exposure to nutritional stress or perhaps an environmental mutagen brought forth a full-blown malignant transformation. Indirect support of this concept may be seen in a report by Branda *et al.*¹³ of a family with an inherited defect of cellular folic acid uptake. Among four generations of this family, there were 34 cases of proven or suspected serious hematologic disease, including five cases of acute leukemia. In another report, Marinello *et al.*¹⁴ described the occurrence of "double minute" chromosomes in 40 of 320 patients with hematologic disease. The abnormal chromosomes resemble and are compatible with fragments arising from chromosome breaks at a fragile site.

VIRAL ONCOGENESIS

There is considerable circumstantial evidence that cervical cancer is related in some way to the herpes simplex virus,¹⁵ a DNA-containing virus. The "retroviruses," which contain RNA, are proved tumor-inducing agents in certain species; they cause RNA-directed synthesis of DNA by reverse transcriptase.¹⁶ There would be good reason to suspect that folic acid-containing coenzymes play important roles in this DNA synthesis just as they do elsewhere.

It is relevant to note that another virus, the even-numbered T-bacteriophages of *E. coli*, contains pteroyl hexaglutamate as an essential component of the tailplate in the region of attachment of the six tail fibers.¹⁷ Treatment of phage particles with conjugase renders them noninfectious but does not alter their morphologic appearance by electron microscopy. It is believed that the folacin component is essential for the recognition of and attachment to specific binding sites on the bacterial cell membrane. If these observations apply, as a matter of general biological principle to human oncogenic viruses, several important questions are raised:

1. Is the site of viral modification of chromosomal DNA unusually susceptible to damage or breakage?
2. Do human oncogenic viruses pass from cell to cell by means of receptors intended for nutrient uptake?
3. Does viral-induced synthesis of a coenzyme (e.g., a folacin-containing polyglutamate) "trigger" cell division and malignant transformation?
4. Since nutrients required for viral proliferation may be different from those of the host, can viruses be attacked by specific metabolic inhibitors without affecting normal pathways?
5. Do viruses and steroid hormones share any common biochemical mechanisms for affecting nuclei (i.e., chromosomal DNA) of target tissues?

SUMMARY

From the foregoing discussion, it is apparent that important new leads are developing which may help explain relationships that were heretofore considered obscure between cancer, nutrition, hormones and viruses. New concepts are emerging and new techniques are being applied. The 1980s promise to be a decade of intense, exciting and fruitful research in man's battle to conquer cancer—or at least some forms of it.

REFERENCES

1. Hertz R, Sebrell WH: Impairment of response to stilbestrol in the oviduct of chicks deficient in *L. Casei* factor. *Science* 100:293-294, 1944.
2. Hertz R: Dietary impairment of estrogen response in the immature monkey. *Proc. Soc. Exp. Biol. Med.* 67:113-115, 1948.
3. Kline IT, et al: Estrogen stimulation of the oviduct in vitamin-deficient chicks. *Endocrinol* 48:345-357, 1951.
4. Whitehead N, et al: Megaloblastic changes in the cervical epithelium: Association with oral contraceptive therapy and reversal with folic acid. *JAMA* 226:1421-1424, 1973.
5. Krundieck CL, et al: Cyclic variations in folate composition and pteroylpolyglutamyl hydrolase (conjugase) activity of the rat uterus. *Am J Clin Nutr* 29:288-294, 1976.
6. Gusberg SD: Current concepts in cancer: The changing nature of endometrial cancer. *N Engl J Med* 302:729-731, 1980.
7. Rizkallah TH, et al: Production of estrone and fractional conversion of circulating androsteneione to estrone in women with endometrial carcinoma. *J Clin Endocrinol* 40:1045-1056, 1975.
8. Butterworth CE Jr, et al: Folate-induced regression of cervical intraepithelial neoplasia (CIM) in users of oral contraceptive agents (OCA). *Am J Clin Nutr* 33:926, 1980.
9. Butterworth CE Jr, et al: Improvement in cervical dysplasia

associated with folic acid therapy in users of oral contraceptives. (submitted for publication).

10. Sutherland GR: Fragile sites on human chromosomes: Demonstration of their dependence on the type of culture medium. *Science* 197:265-266, 1977.
11. Sutherland GR: Heritable fragile sites on human chromosomes. I. Factors affecting expression in lymphocyte culture. *Am J Hum Genet* 31:125-135, 1979.
12. Sutherland GR: Heritable fragile sites on human chromosomes. II. Distribution, phenotypic effects and cytogenetics. *Am J Hum Genet* 31:136-148, 1979.
13. Branda RF et al: Folate-induced remission in aplastic anemia with familial defect of cellular folate uptake. *N Engl J Med* 298:469-475, 1978.
14. Marinello MJ et al: Double minute chromosomes in human leukemia (letter to the editor). *N Engl J Med* 704-705, 1980.
15. Rotkin, ED: A comparison review of key epidemiological studies in cervical cancer related to current searches for transmissible agents. *Cancer Res* 33:1353-1367, 1973.
16. Bishop JM: The molecular biology of RNA tumor viruses: A physician's guide. *New Engl J Med* 308:675-682, 1980.
17. Kozloff LM, et al: Bacteriophage tail components, I, Pteroylpolyglutamates in T-even bacteriophages. *J Virol* 5:726-739, 1970.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physicians Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

Selected Abstracts with Comments

Nora JJ: Identifying the child at risk for coronary disease as an adult. *J Pediatr* 97:706, 1980

The concept of risk factors for ischemic heart disease (IHD) in adults has been extended to the pediatric age group. During the past ten years a large body of epidemiologic and experimental data has supported the relevance of these risk factors to adult IHD. However, continuing efforts are required in order to achieve the incorporation of this concept into the practice of preventive pediatrics. The most important of these factors is heredity, and is manifested both by the presence of premature (i.e., before age 65) myocardial infarction in a relative, and by the presence of hyperlipoproteinemia (specifically, a high level of low-density lipoprotein) in the child. Other risk factors are hypertension, smoking, lack of exercise and obesity. A questionnaire is proposed to assist in elicitation of appropriate historical information, and a scoring system has been devised to quantify the degree of risk.

Comment: Dr. Nora, a geneticist, has summarized the knowledge of hereditary and environmental predisposition to IHD in the review. He urges incorporation of this information into daily practice. Test yourselves as up-to-date practitioners by answering the following:

1. Are you asking for information concerning premature heart attack and hypertension in all new families coming to your office?
2. Are you measuring blood pressure routinely?
3. Are you measuring serum cholesterol in all school children in a search for those above the 95th percentile?
4. Are you urging the avoidance of overfeeding starting with neonates, and the "prudent diet" and daily exercise throughout childhood and adolescence?
5. Are you doing everything you can to discourage youngsters from smoking?

(O.R. Levine, M.D.)

Cummins RO, et al: Communication failure in primary care. *JAMA* 243:1650, 1980

In a two-physician general practice 233 referrals (5.3 percent of patient visits) were made to consultants in university-affiliated emergency rooms, university specialty clinics and private specialists for a specific medical problem. All referred patients were accompanied by a referral letter and other necessary information. When a patient was referred to an emergency room, the referral was addressed to the physician in charge. Whenever possible a telephone call to the consulting physician was made. In every instance, written and verbal communication through followup information was requested. Written summaries, laboratory and x-ray data were given to the patient or family to deliver directly to the consultant.

Sixty days were allowed for receipt of followup informa-

tion. If no information was received within 60 days, the consultant was contacted to ascertain whether the patient had kept his appointment.

During the six months of the study, 65 patients were referred to university-affiliated emergency rooms, 69 were referred to university-affiliated specialty clinics and 78 were referred to private consultants. Followup information was received from 48 percent of emergency room consultations, 59 percent from specialty clinics and 78 percent from private specialists.

Comment: The poor communication from the two university medical centers in this study may reflect the disdain of the LMP by academic physicians. The responsibility for communication may not be defined particularly if the patient is seen by a medical student, resident or fellow. Obviously the private specialist who intends to build a private referral practice communicates promptly with the referring physician because he expects to continue receiving referrals from community-based physicians.

Followup by personal letter is most satisfactory since it provides a written record to be included in the patient's chart. Telephone calls from consultants are also very useful because they provide the opportunity for discussion and in-depth communication which enhances the referring physician's ability to provide ongoing supervision, counseling and continuity of care. Written and verbal requests for and responses to consultation are needed between the referring physician and consultant in order to provide the best patient care.

(J. Alexander, M.D.)

Roush GC: Psychoactive medicinal and nonmedicinal drug use among high school students. *Pediatr* 66:709, 1980

Through elaborate statistical manipulation of data collected in 1972, the authors demonstrate a positive correlation between nonmedicinal drug use (alcohol, cigarettes, marijuana) among adolescents and physician prescribing of psychoactive drugs. The authors are quick to point out that these results do not necessarily indicate that the physician causes illicit drug use but he/she may contribute to it.

Comment: Many justifiable criticisms might be hurled at this study. However, we all should carefully heed the caveat

*Abstracted from *Department of Pediatrics Newsletter*, CMDNJ, New Jersey Medical School, Newark—Vol. 3, No. 1 (January) 1981. Selections are made by Richard H. Rapkin, M.D., Professor of Pediatrics and Medical Director of Children's Hospital, Newark, who is editor; Franklin C. Behrle, M.D., Professor and Chairman of Pediatrics; and Shyan C. Sun, M.D., Associate Professor of Pediatrics and Director, Department of Neonatology, Children's Hospital, Newark, who are coeditors. Comments are prepared by them and their associates.

against our casual use of psychoactive drugs—the prescription of a minor tranquilizer to a nervous teenager might be the quickest way to ease the nervousness, but this simple solution also transmits the implied message that pills (or some other substance) is the appropriate way to solve all problems.

(R.L. Johnson, M.D.)

Dwyer J: Diets for children and adolescents that meet the dietary goals. *Am J Dis Child* 134:1073, 1980

In an excellent review, the author outlines the current recommendation for child and adolescent dietary goals. More importantly, she explains the rationale for these goals and lists strategies to help parents implement them.

Comment: This article should be mandatory reading for every practitioner who is called upon to tell parents how to help their children eat properly. One caution, however; don't set your expectations too high—it's easy to lead a horse to the most nutritious bale of hay. It's another thing indeed to make him eat it.

(R.L. Johnson, M.D.)

Steele MW: Population screening for carriers of recessively inherited disorders (Editorial). *Lancet* 2:679, 1980. **Lessons from the American Tay-Sachs program.** (Letter). *Lancet* 2:914, 1980

A review of the current status of "Population screening for carriers of recessively inherited disorders" is presented in the September 27, 1980 editorial section of *The Lancet*. One can subdivide these screening efforts into three categories: (1) neonatal screening where early treatment is feasible (e.g., PKU, hypothyroidism, galactosemia), (2) screening of specific ethnic groups for detection of the carrier state (e.g., population for Tay-Sachs carrier status, Black for sickle cell trait, Italian, Greek, Mediterraneans for thalassemia), and (3) generalized widespread screening for recessively inherited disorders or prenatal detection of birth defects (e.g., cystic fibrosis carrier detection [presently not available], maternal alpha-fetoprotein for neural tube defects, amniocentesis for pregnant women over 35 years for detection of Down's syndrome). The article and a letter by Dr. Mark Steele of Pittsburgh point out a number of problems encountered with these mass screening efforts.

Questions are raised: (1) best time to screen for carrier status? (newborn easiest; my feeling is non-pregnant couples), (2) what does it mean to be a carrier?, (3) how to standardize and control quality of laboratory tests?, (4) how to provide adequate counseling services and resources? All remained unresolved. Further concerns are about anxiety and negative carry-over effects in those screened. In a three-year Canadian study of 19 identified carrier couples for Tay-Sachs (i.e., both husband and wife identified as carriers by a mass screening program, at risk to have a child with Tay-Sachs), only two couples attempted subsequent pregnancies despite the availability of prenatal diagnosis. Dr. Steele extrapolates the cost of preventing one case of Tay-Sachs disease: it may have been the loss of about 35 normal children who were never conceived. Dr. Steele concludes that such screening programs have not been successful (and by implication potentially harmful) and urges the reordering of funding priorities to "more molecular/genetic cytogenetic diagnostic techniques and "gene" therapy and not well-intentioned eugenic programs or even retrospective counseling."

Comment: Like the soft drink company which went

bankrupt when they stopped production at "six-up," Dr. Steele's argument is a polemic near-miss. Who would argue that successful treatment of Tay-Sachs disease is not preferable to aborting a Tay-Sachs fetus, but it "ain't available." Who would argue that funding basic molecular research should not receive high priority, but should it preclude the availability of screening programs, educational and counseling information and informed decision making on the part of the individuals so screened?

The concerns over the anxiety-laden negative side effects of identified carriers is real. But how does one balance this out? By what emotional Apgar score can one equate the sexual or reproductive anxiety of a Tay-Sachs carrier couple with the emotional burden of caring for a child with Tay-Sachs disease. Is not knowledge that a couple may be at high risk to have a child with a severe genetic disorder an acceptable and rational reason for such a couple to alter their reproductive behavior? Is that reason any less acceptable than an upwardly mobile working couple who do not choose to be burdened by sticky-fingered children interfering with their lifestyle, or the couple who, for economic reasons, choose not to have children, or the couple in a developing nation who will opt for a transistor radio in exchange for sterilization because of the government's concern over overpopulation? Certainly, Malthus for one would be pleased. I cannot get overly concerned that a minority of the at-risk population will voluntarily come to get screened. In my view, any medical information that an individual can obtain about himself that will help that individual make decisions about himself or his reproductive behavior is in itself justification for such a program. I need to be sure that current information is widely available, ideally to all. I need not be concerned that any individual chooses to ignore it, makes "bad" choices or that studies show that experienced genetic counseling may not alter preconceived notions in a good many instances. From my simplistic viewpoint, categorizing screening programs as successes or failures, good or bad, makes little sense. In that they are well constructed and may add to the individual's ability to make decisions about his progeny (whatever that may be) would seem to be the yardstick by which such program should be measured.

(F. Desposito, M.D.)

Nadler HL, et al: Intrauterine detection of cystic fibrosis. *Pediatr*, 66:690, 1980

Dr. Nadler previously has shown that patients with cystic fibrosis (CF) are deficient in the protolytic hydrolysis of arginine ester in their saliva and plasma. This current paper deals with the extension of this work to amniotic fluid indicating that normal amniotic fluid contains reactive proteases while three mid-trimester amniotic fluids from women who previously had delivered children with CF had a reduction in the level of titrable proteases upon isoelectric focusing of amniotic fluid. Thirteen prospective pregnancies of known carriers (e.g., at one-in-four risk to have a child with CF) were studied with three instances of CF predicted and ten non-affected infants; no errors in prediction were made in this small series.

Comment: Good stuff. Three brief reservations: (1) At present, this methodology cannot distinguish the carrier from the normal; thus it is only being offered on an experimental basis to families who have identified themselves as carriers of the CF gene by having a previous child with CF. (2) It has been presumed that CF may be due to several genetic variants (so-called genetic heterogeneity) based on

varied clinical presentations. One might assume that some genetic variants may not show the deficiency in proteases noted in the majority of CF patients. Thus, some false-negative amniotic fluid results might be observed in such instances. (3) Will there be other conditions (genetic or otherwise) or apparently normal pregnancies which will have diminished protease activity . . . that is, false-positives? Exciting methodology; we should expect to hear more about this. (F. Desposito, M.D.)

Winick M: The Web of Hunger—Nutrition and Brain Development. *Natural History* 89:6 (December) 1980

Dr. Winick describes in broad terms what we know about the disastrous effects of malnutrition on the human brain prenatally and during early postnatal life. He then goes on to discuss the more complex issue of lack of stimulation as a cause of these changes, rather than the malnutrition itself. (Animal data suggest that malnutrition acts by "functionally isolating" the animal from stimuli necessary for normal brain development.) He then discusses the available human information from adoption outcomes in Korean orphans, suggesting that much of the deficit due to malnutrition *but not all* could be ameliorated by a stimulating environment. He suggests that malnutrition exerts two separate effects: the first is independent of environment and results in fewer cells and less complex interconnections in the brain; the second is a result of apathy in the starved child and the usual dreadful environment associated with starvation, leading to permanent deprivational syndromes. This latter effect can be prevented by restoration of nutrition and a stimulating environment. The possible biochemical basis of the hypothesis is discussed briefly.

Comment: It certainly seems that our deprived, failure-to-thrive patients are getting a double whammy, but at least some of their deficits are reversible. Now all we have to do is figure out how to get them all into superstimulating and caring homes! The implications for areas of the world suffering famine are overwhelming.

The publication of this nontechnical view in *Natural History* should bring it to the attention of at least some non-medical readers who possibly have the power to begin to do something about it.

(L. Bagdon, M.D.)

Rosenn DW, et al: Differentiation of organic from nonorganic failure-to-thrive syndrome in infancy. *Pediatr* 66:698, 1980

The authors developed a nine-item scale, with each item to be scored on a seven-point system, which seemed to differentiate between organic failure to thrive, non-organic failure to thrive, and other sick infants. The results (requiring some time-consuming, three-times-a-day observations) were fairly consistent; the technique "cannot . . . be expected to always distinguish organic from nonorganic FTT." It may assist in making the determination sooner in the occasional case in which weight gain does not begin for two to three weeks. The behaviors described in detail may give additional clues as to the nature of the mother-child relationship that leads to deprivational FTT.

Comment: The comparison groups consisted of only eight,

ten and seven infants; results must be regarded as quite preliminary. The technique, for which a manual is needed, involves scoring three times a day every day by an examiner with some practice for validation. It remains to be seen if this can be useful in the hands of anyone but the originators; if so, it certainly will be more helpful than the elaborate workups still being done.

(L. Bagdon, M.D.)

Klackenberg G: What happens to children with retarded speech at three? *Acta Paediatr Scand* 69:681, 1980

Of 212 nonretarded children with speech delay at three years, a remarkable 175 still were being followed at age 20. All identifiable neurological, retardation, audiological, and "cerebral palsy" syndromes were excluded. The children were at significantly higher risk of school failure, social failure, and multiple behavioral symptoms than a comparison group. Is this relatively poor prognosis due to an inherent disorder or did the language deficit contribute to subsequent lack of stimulation? Significant numbers of speech-delayed, three-year-olds did well, but the risk of persistent significant disorder was much higher than a control group.

Comment: Further evidence that "wait and see if he outgrows it" is a dangerous approach to speech delay. We should do all we can to maximize language stimulation. Speech stimulation programs with instruction for the parents in providing a good linguistic environment in the home are available in any good speech department.

(L. Bagdon, M.D.)

Rogan W: The sources and roots of childhood chemical exposures. *J Pediatr* 97:861, 1980.

This article presents a brief review of man's effect on his macro and micro environment. The author discusses various occupational exposure effects on humans; for example, oligospermia with Kepone exposure. He also discusses industrial exposures; example, the El Paso lead smelter, and environmental contamination with PCB, DDT and lead. He further discusses the problems coincident with current modern living, i.e., living in well-insulated homes contaminated with formaldehyde, carbon monoxide and other chemicals. In addition, he discusses the larger scale disasters of Minomoto and Love Canal, as well as Se Veso, Italy. Dr. Rogan presents his motive for this article in a very clear fashion: many of us are exposed to a large number of chemicals on a daily basis and disease syndromes associated with these exposures are becoming more and more apparent. He goes on to specifically state that a high suspicion must be maintained that illness may be related to chemical exposure and in only such a way can poison syndromes be unmasked and hopefully prevented.

Comment: This pithy discussion should be on the required reading list of anyone interested in the environment and its effects on child health. We all need to become activists in the elimination of unnecessary deleterious exposures to chemicals and foreign substances put into our environment by industry and the inadvertent use in our homes.

(S. Marcus, M.D.)

Insulin—The Old and the “New”

Many physicians are bombarded daily by questions from their diabetic patients as to the “new” insulins. What are they? Do I need to change my dose? Why are they more costly? Despite the information from the major manufacturers of insulin on a worldwide base—Lilly, Squibb, Novo and Nordisk—there is still some confusion.

The “new” insulins are really the old insulins in a more purified form. That simply means that there is less extraneous content, mainly proinsulin, but also less of the other noninsulin protein materials such as glucagon, somatostatin and peptides. New purification techniques have led to removal of 99 percent or more of such minor “contaminants” so that insulin produced in the United States today is pure enough to be labeled as single-peak insulin by gel chromatography. The “purity index” used is the proinsulin content in parts per million (ppm). The “old” Lilly Regular Insulin, for example, contained <3,000 ppm of proinsulin, while the “new, improved” Lilly Regular Insulin has a purity index of <50 ppm. This is a mixture of beef and pork insulin, while the same manufacturer also makes separate beef insulin and separate pork insulin with a purity index of <10 ppm.

This whole issue was prompted by two Danish manufacturers, Novo and Nordisk, who have entered the very competitive United States insulin market. Whereas Lilly controls the lion’s share of the U.S. insulin sales, those two companies have the same position in Europe. Like all good businesses, each has eyed the other’s turf and is looking to take away part of the respective U.S. and European insulin markets.

The Novo and Nordisk insulins are said to be the purest (purity index <1 ppm) in the world, but they are also the most expensive to manufacture and to the patient. The scientific debate that rages is whether or not such purity is worth the added cost to the diabetic patient. The marketing experts use the purity index to sell their product, but the U.S. Food and Drug Administration (FDA) has expressed some doubt as to the significance of such added purity to the individual patient.

Most diabetics do well with the conventional insulins, so one must question the justification of the added cost of the purified insulins, which consist of insulin from a single animal source (beef or pork) as well as a mixture of the two (see Table).† It is unlikely that the patients will continue to pay the added cost without good reason.

Since the insulin molecule obtained from pigs is identical to human insulin, except for a single amino acid, there seems to be an attraction to use the porcine variety of insulin. The FDA recommends the use of the highly purified insulin in:

1. Patients who exhibit local or systemic allergic reactions to conventional insulin, and
2. Patients who develop lipodystrophy from conventional insulin.

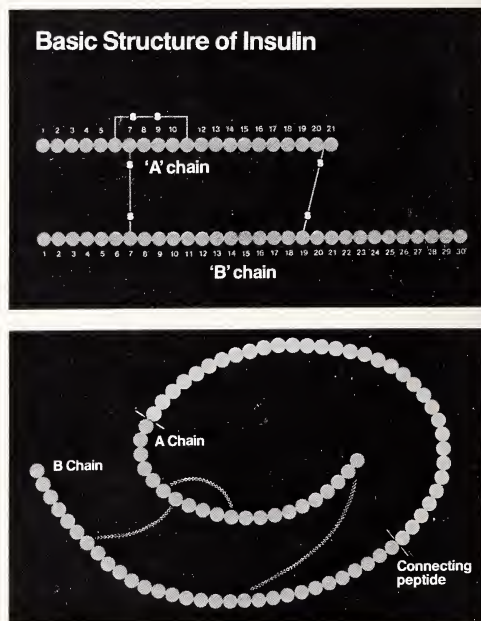
There are some other hypothetical although debatable indications for the purified insulins:

1. Patients exhibiting insulin resistance,
2. All diabetics whose onset is in the young age group,
3. All patients who are likely to receive insulin on a temporary basis, e.g., the noninsulin-dependent diabetic during stress (such as surgery or a serious infection), gestational diabetics, and so on.

When one prescribes the purified insulins, it is important to monitor the patients carefully as a reduction in dose of ten to 20 percent may be needed in some of them.

The name of the game today is cost-benefit ratio. Despite the marketing claims, each physician who prescribes insulin today should make a decision as to purified insulin versus conventional insulin on a scientific basis, but the added cost of purification cannot be ignored.

A.K.



The above illustration was provided by Novo Laboratories, Inc., Wilton, CT.

†The new insulins: *Am J Nursing* 81:147, (Jan) 1981

Characteristics of Older and Newer Insulin Products*

Type of Insulin	Product Name/ Manufacturer	Animal Source	Onset of Action	Duration of Action	Purity Index: Proinsulin Content (ppm)
Rapid Acting					
crystalline zinc	Regular Iletin-Lilly	beef/pork	<1 (hrs.)	5-7 (hrs.)	<3,000
	Regular Iletin-Lilly	beef	<1	5-7	<3,000
	Regular Iletin-Lilly	pork	<1	5-7	<3,000
	Regular Iletin-				
	New Improved-Lilly	beef/pork	<1	5-7	<50
	Regular Iletin II-Lilly	beef	<1	5-7	<10
	Regular Iletin II-Lilly	pork	<1	5-7	<10
	Actrapid-Novo	pork	<1	5-7	≤1
	Nordisk Quick-Nordisk	pork	<1	5-7	≤1
	Regular-Squibb	beef/pork	<1	5-7	<10,000
prompt, zinc suspension	Semilente Iletin-Lilly	beef/pork	<1	12-16	<3,000
	Semilente Iletin-				
	New Improved-Lilly	beef/pork	<1	12-16	<50
	Semitard-Novo	pork	<1	12-16	≤1
	Semilente-Squibb	beef	<1	12-16	<10,000
Intermediate					
globin zinc	Globin Zinc-Squibb	beef/pork	1-2	18-24	<10,000
isophane	NPH Iletin-Lilly	beef/pork	2	18-24	<3,000
suspension	NPH Iletin-Lilly	beef	2	18-24	<3,000
	NPH Iletin-Lilly	pork	2	18-24	<3,000
	NPH Iletin-				
	New Improved-Lilly	beef/pork	2	18-24	<50
	NPH Iletin II-Lilly	beef	2	18-24	<10
	NPH Iletin II-Lilly	pork	2	18-24	<10
	Nordisk Retard NPH-Nordisk	pork	2	18-24	≤1
	Isophane suspension-Squibb	beef/pork	2	18-24	<10,000
zinc suspension	Lente Iletin-Lilly	beef/pork	2-4	18-24	<3,000
	Lente Iletin-Lilly	beef	2-4	18-24	<3,000
	Lente Iletin-Lilly	pork	2-4	18-24	<3,000
	Lente Iletin-				
	New Improved-Lilly	beef/pork	2-4	18-24	<50
	Lente Iletin II-Lilly	beef	2-4	18-24	<10
	Lente Iletin II-Lilly	pork	2-4	18-24	<10
	Lentard-Novo	beef/pork	2-4	18-24	≤1
	Monotard-Novo	pork	2-4	18-24	≤1
	Lente-Squibb	beef	2-4	18-24	<10,000
Slow					
extended zinc suspension	Ultralente Iletin-Lilly	beef/pork	4-6	36	<3,000
	Ultralente Iletin-				
	New Improved-Lilly	beef/pork	4-6	36	<50
	Ultratard-Novo	beef	4-6	36	≤1
	Ultralente-Squibb	beef	4-6	36	<10,000
protamine zinc suspension	Protamine, Zinc and Iletin-Lilly	beef/pork	4-6	36	<3,000
	Protamine, Zinc and Iletin-Lilly	beef	4-6	36	<3,000
	Protamine, Zinc and Iletin-Lilly	pork	4-6	36	<3,000
	Protamine, Zinc and Iletin-New Improved-Lilly	beef/pork	4-6	36	<50
	Protamine, Zinc and Iletin II-Lilly	beef	4-6	36	<10
	Protamine, Zinc and Iletin II-Lilly	pork	4-6	36	<10
	Protamine, Zinc Suspension- Squibb	beef/pork	4-6	36	<10,000

*Reprinted from *American Journal of Nursing*, Vol. 81, No. 1 (Jan) 1981, p. 147. Copyrighted by the American Journal of Nursing Company.

215th Annual Meeting

May 16-19

Meadowlands Hilton Hotel—Secaucus

(See housing application—p. 270, this issue)

DAILY SCHEDULE

Friday, May 15, 1981

3:30 p.m.—Board of Trustees' Meeting

Saturday, May 16, 1981

8:00 a.m.—Registration Opens
9:00 a.m.—Message Center Opens
9:30 a.m.—Symposium on Medicine and Religion
11:00 a.m.—Meeting—NJ Committee on Trauma
11:00 a.m.—Meeting—MSNJ Committee on Publication with Editorial Board
11:30 a.m.—Luncheon—NJ Committee on Trauma
12:00 noon—Exhibits/Coffee Lounge/Auxiliary Arts and Hobbies/AMA-ERF Boutique Open
12:00 noon—Golden Merit Award Ceremony followed by Golden Merit Award Reception
12:30 p.m.—Annual Spencer T. Snedecor Trauma Oration
2:00 p.m.—House of Delegates
3:30 p.m.—Reference Committee Meetings: "A", "B", "D", "G", Constitution & Bylaws
5:30 p.m.—Jefferson Medical College Alumni Reception

Sunday, May 17, 1981

8:00 a.m.—Registration Opens
9:00 a.m.—Message Center/Exhibits/Coffee Lounge/Auxiliary Arts and Hobbies/AMA-ERF Boutique Open
9:00 a.m.—Scientific Sessions: Allergy, Dermatology, Emergency Medicine, Psychiatry
10:00 a.m.—Reference Committee Meetings: "C", "E", "F", "H"
10:00 a.m.—Auxiliary Pre-Convention Board Meeting
11:30 a.m.—Auxiliary Brunch
1:00 p.m.—Luncheon, NJ Chapter, American College of Emergency Physicians
1:00 p.m.—Scientific Sessions: Anesthesiology, Obstetrics and Gynecology, Neurosurgery and Neurology, Nuclear Medicine, Radiology, Ophthalmology, Otolaryngology
1:30 p.m.—Meeting—Widows and Orphans Society
2:00 p.m.—Auxiliary Program
3:00 p.m.—House of Delegates
6:30 p.m.—Inaugural Reception Honoring President-Elect and Mrs. Goracci
Hosts—MSNJ and Gloucester County

Medical Society

All members, official guests, and their wives, and Auxiliary members are cordially invited
Tickets: \$5.00 per person

8:00 p.m.—Inaugural Dinner-Dance
Hosts—MSNJ and Gloucester County Medical Society
Music and Dancing: Cliff Kollmeier and his Orchestra. Tickets: \$40.00 per person

Monday, May 18, 1981

7:00 a.m.—JEMPAC Breakfast
8:00 a.m.—Registration Opens
9:00 a.m.—Auxiliary General Session
9:00 a.m.—Message Center/Exhibits/Coffee Lounge/Auxiliary Arts and Hobbies/AMA-ERF Boutique Open
9:00 a.m.—Scientific Sessions: Cardiovascular Diseases, Chest Diseases, Pediatrics, Family Practice, Medicine, Clinical Pathology, Orthopaedic Surgery, Surgery, Oncology
12:00 noon—Luncheons: NJ Orthopaedic Society, NJ Society of Physical Medicine and Rehabilitation
1:00 p.m.—Luncheon—NJ Chapter, American College of Chest Physicians
1:00 p.m.—Auxiliary—President's Luncheon
1:00 p.m.—Scientific Sessions: Alcohol and Drug Abuse Program, Gastroenterology, and Proctology, Physical Medicine and Rehabilitation
3:00 p.m.—House of Delegates
3:00 p.m.—Exhibits/Coffee Lounge/Auxiliary Arts and Hobbies/AMA-ERF Boutique Close
6:00 p.m.—JEMPAC Wine and Cheese Reception

Tuesday, May 19, 1981

7:15 a.m.—Breakfast Meeting—Essex County Medical Society
8:00 a.m.—Auxiliary County Presidents' Breakfast
8:30 a.m.—Registration Opens
9:00 a.m.—House of Delegates
10:00 a.m.—Auxiliary Post-Convention Board Meeting
12:00 noon—Registration Closes
2:00 p.m.—Annual Meeting—Board of Governors of MILE
3:00 p.m.—Board of Trustees' Meeting

Report of the Nominating Committee

Offices To Be Filled by Election 1981 Annual Meeting

Alfred A. Alessi, M.D., Chairman

Office	Term	Nominee and County
President-Elect	1 year	Howard D. Slobodien, M.D., Middlesex
1st Vice-President	1 year	Alexander D. Kovacs, M.D., Union
2nd Vice-President	1 year	Frank Y. Watson, M.D., Essex
Trustees:		
1st District	3 years	Douglas M. Costabile, M.D., Union
1st District	3 years	William Greifinger, M.D., Essex
2nd District	3 years	John J. Crosby, Jr., M.D., Hudson
2nd District	3 years	Michael R. Ramundo, M.D., Passaic
3rd District	3 years	Frank Campo, M.D., Mercer
3rd District	3 years	Palma E. Formica, M.D., Middlesex
4th District	3 years	John P. Kengeter, M.D., Ocean
Judicial Councilors:		
1st District	3 years	Gabor Somjen, M.D., Morris
4th District	3 years	Frederick W. Durham, M.D., Camden
AMA Delegates:		
	1 year	Myles C. Morrison, Jr., M.D., Morris
	2 years	Edward A. Schauer, M.D., Monmouth
	2 years	William J. D'Elia, M.D., Monmouth
AMA Alternate Delegates:		
	2 years	William E. Ryan, M.D., Mercer
	2 years	Howard D. Slobodien, M.D., Middlesex
	2 years	James H. Spillane, M.D., Warren
	2 years	Frank Y. Watson, M.D., Essex
Delegates and Alternate Delegates to Other States		
New York:		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	F. Sterling Brown, M.D., Atlantic
Connecticut:		
Delegate	1 year	Merton L. Griswold, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation:		
5th District	3 years	Robert F. Nunn, M.D., Cape May
6th Member	3 years	Howard H. Lehr, M.D., Union
Medical Services:		
5th District	3 years	John J. Pastore, M.D., Cumberland
6th Member	3 years	Frank A. Wolf, M.D., Warren
Mental Health:		
5th District	1 year	Friedrich K. Racke, M.D., Cumberland
3rd District	3 years	Joseph J. Kline, M.D., Mercer
6th Member	3 years	Joseph P. Cillo, M.D., Union
Public Health:		
5th District	3 years	Samuel C. Ingraham, II, M.D., Cape May
6th Member	3 years	Patrick J. McGovern, M.D., Hudson
Public Relations:		
2nd District	3 years	Vacancy
5th District	3 years	John J. Pastore, M.D., Cumberland
Standing Committees:		
Annual Meeting	3 years	Arthur C. Dietrick, M.D., Burlington
Auxiliary Advisory	3 years	J. James Pegues, M.D., Burlington
Finance and Budget	3 years	Harry M. Carnes, M.D., Camden
Medical Defense		
and Insurance	3 years	E. Arthur Kratzman, M.D., Union
Medical Education	3 years	Edwin W. Messey, M.D., Burlington
Publication	3 years	Dirck L. Brendlinger, M.D., Burlington

DOCTORS' NOTEBOOK

Trustees' Minutes February 1, 1981

A regular meeting of the Board of Trustees was held on Sunday, February 1, 1981, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Chiropractors . . . Noted that an article in *The New York Times* of February 1 stated that a federal court jury had returned a not guilty verdict in a five-year-old antitrust suit instituted by five chiropractors against the AMA, 15 other medical groups and several individuals.

Legal Services Plan . . . Noted that 3400 members of MSNJ have enrolled in the legal services plan; 37 physicians received inquiries from the State Board of Medical Examiners. Seventeen of these resulted in a formal hearing; six involved dealings with investigators and 14 required written response. Twenty of these cases have been resolved. There was no cause for action in fifteen; there was one letter of reprimand and four payments of fine, but no suspension or revocation. Seventeen cases still are pending.

MSNJ Financial Statements . . . Received and reviewed a balance sheet and statement of revenue and expenses for seven months ending December 31, 1980.

MSNJ Membership

1. **Exempt Members** . . . Noted that a study will be made to determine the options available concerning the increasing number of dues-exempt members, especially in relation to the intent of the Bylaws regarding members who are in the armed services and emeritus members who are semi-retired.

2. **CME Requirements** . . . Noted that 32 memberships were terminated in December 1979 for failure to comply with CME requirements. One month later 17

had submitted their credits and were reinstated. As of December 31, 1980, 130 memberships were terminated. During the month of January (1981) the figure was reduced to 101 and it is estimated that by March 60 percent will have met CME requirements and be brought back into membership.

3. **1981 Membership Dues** . . . Noted that as of mid-January 1981 dues had been received for 3,876 members. It is anticipated that 80 percent of the total dues will have been paid by March.

Legal Matters

1. **State Board of Medical Examiners vs. Driggs** . . . Noted that the State Board of Medical Examiners has agreed to order a new trial in this case and a hearing will be scheduled.

2. **Excessive Fee Regulation** . . . Directed that a proposal utilizing the Society's judicial mechanism be presented to the State Board of Medical Examiners for dealing with alleged charges of excessive fees. The concept of disciplinary action for unconscionably charging excessive fees is supported but it is felt that another committee for such a review is not warranted. The judicial mechanism does work, is effective in evaluating physicians' fees and ethics, and should be used by the State Board of Medical Examiners in the development of any regulatory system. This entire matter has been discussed with specialty societies and county medical societies (Burlington and Mercer Counties have submitted resolutions and Morris County has communicated in writing to the Board) and it was the consensus that the State Board of Medical Examiners should take cognizance of our judicial system.

3. **Nurse/Midwives Regulations** . . . Decided to take no action on the difficulties encountered in the implementation of the Nurse/Midwife regulations after discussion with the presidents of the New Jersey Society of Anesthesiologists and the New Jersey Chapter of the American College of Obstetricians and Gynecologists.

4. **Radiological Regulations** . . . Noted that opinion of the Court is still pending in the matter of mandated provision of radiological services to chiropractors.

AMA National Awards Program . . . Noted that a silver award in Category 6 of the AMA National Awards Program for Medical Speakers will be presented at the AMA National Leadership Conference to James E. George, M.D., J.D., Director of MSNJ's Department of Liability Control. This was based on a video tape on anesthesia produced by Dr. George.

New Jersey Hospital Association . . . Received as informative a report from the New Jersey Hospital Association on activities under way in other states regarding the use of DRGs:

- The State of Georgia is beginning to utilize a DRG system, but there is a court suit pending as to whether hospitals can be forced to participate.
- In the State of Washington there is a cost-per-case system under way.
- In the State of Maryland a GIR program has been developed which basically is a DRG system.
- Grants have been awarded to New York and Massachusetts for the development of DRG programs.
- The Veterans Administration Hospitals are going to a DRG system for allocation of monies.
- The Federal Government has taken the position that a cost-per-case method has great potential and intends to use it in Medicaid and Medicare programs, first in pilot cases and then across the country.

New Jersey Medical School Delegation Report on AMA Interim Meeting

. . . Approved a recommendation that the report from the medical students on the AMA Interim Meeting be brought to the attention of the membership via *The Journal*. The following is the complete report:

1. Special thanks to the Medical Society of New Jersey Delegation to the AMA for al-

lowing the students to sleep in and about the MSNJ Hospitality Suite, and for the generous help and cooperation shown to the students throughout the meeting.

2. There were over 30 resolutions brought before the student assembly (business meeting), and, due to the large amount of time needed for this, the student section was unable to officially consider *any* of the scheduled business of the AMA House of Delegates.

3. Student issues that were forwarded to the AMA House of Delegates included: support for the legislative intent of the Equal Rights Amendment and the extension of the work of the Ad Hoc Committee on Women in Organized Medicine. (Both of these were referred to the Board of Trustees, along with the Ad Hoc Committee's report, for report back to the House of Delegates in June 1981.) Also forwarded were requests for continued funding of the Goldburger Nutrition scholarships which allow students to travel to elective rotations in clinical nutrition; opposition to the glorification of violent and daredevil stunts on television; and requests for follow-up and additional activity against smoking. (Funding of the Goldburgers has been arranged by the AMA-ERF Foundation, beginning in 1981.)

4. Internally, the Student Business Section changed its name to the Medical Student Section, referred a resolution which called for the creation of a standing policy manual, and voted to retain the American Medical Student Association (AMSA) appointed member of the section governing council. A late resolution requested similar representation on AMSA's Board of Trustees.

5. Student testimony in response to a questionnaire about the National Health Service Corps reflected that this is a valuable alternative to loans and the military, and also provides essential services in some areas. Expansion of this program and the creation and strengthening of the state-level service contingent programs were called for. It was stressed that these programs should be in addition to loan programs, so that a student would not be forced into a care model or geographic area he or she did not wish to be in.

6. The Resident Physician Section, with the assistance of the Student Section, managed to convince the AMA Board of Trustees to recommend rejection of the revised Essentials of Accredited Residencies, and the delegates approved this recommendation. The changes would have fully defined housestaff as students, and would have eliminated the requirements for bilateral written agreements (contracts) between the resident and the hospital. The four other parent bodies of the Liaison Committee on Graduate Medical Education (LCGME) had already approved the new Essentials, which now will have to be renegotiated. The importance of this to students is considerable, since we will soon be housestaff and would like the protection contracted employees are entitled to; the action of the Board shows their commitment to alter previous positions when needed to serve one of their constituency groups (residents).

Representatives who attended were Jonathan Klein, Delegate, Charles Spingola, Alternate Delegate, Peter Snieckus, Kim Sullivan and Peter Sayer.

Evaluation of Medicaid Payment . . . Approved a recommendation from the Council on Legislation that the experimental study being conducted by the Department of Human Services, Division of Medicaid, be supported and that legislation be drafted that would mandate an annual review and upgrading of the program (Medicaid payments).

Senate Bill S-382 . . . Authorized the staff to indicate a change of position on Senate Bill S-382 (previously disapproved) provided the studies support the interpretation of the Medical Inter-Insurance Exchange.

Note: S-382 limits the awarding of damages to a maximum of \$100,000 where the decedent was a minor at the time of the injury which resulted in death; however, a recent New Jersey Supreme Court decision has overturned all prior case law on proof of economic loss in damage situations in the wrongful death of a minor. MIE fears that without a limit the \$100,000 well may be exceeded. It is awaiting studies to support this contention.

Current State Legislation . . . Approved a recommendation from the Council on Legislation to accept the positions recommended on the following bills of medical interest:

S-48 Scardino—Department of Public Advocate

Restructures the Division of Mental Health Advocacy within the Department to create a Division of Mental Health Legal Counseling and Assistance which shall be staffed by multi-disciplined personnel.

Jurisdiction is all encompassing and relates to counseling, advising, and representing patients on all admissions, confinements, or retainments in mental health facilities, transfers, treatment, etc. The Division also has the right to inspect and visit, at any time, any center, clinic, hospital, or facility for patients who are mentally disordered. **DISAPPROVED**, because this bill takes the treatment of the patient out of the hands of the physician, provides an unbalanced legal representation, and would divert funds necessary for patient care to non-health areas.

S-865 Orechio—Electrologists Licensing Act Authorizes the State Board of Medical Examiners to license electrologists. An electrologist is "a person who professionally removes hair from apparently normal skin of the human body by electrical, electronic, or other technical, scientific methods approved

by the Board." The advisory board is to consist of three electrologists and three medical doctors, preferably dermatologists. **DISAPPROVED**, because existing public health controls make this legislation unnecessary.

S-1321 Musto—Blue Shield

Amends the enabling act to provide that chiropractors be included as eligible providers when services are rendered within the scope of their practice. (*N.B.* The NJSBME voted to approve this legislation 9/15/80) **LAW c. 158 ('80). NO ACTION**

S-1358 Scardino—Cystic Fibrosis

Extends the benefits of the cystic fibrosis program under the crippled children's program to adults with that disease. **APPROVED**

S-1367 Lipman—Hereditary Disorders

Creates a Commission on Hereditary Disorders. The Commission is to establish detection and management programs, gather and disseminate information, establish record-keeping systems, investigate charges of discrimination, and continually evaluate the need and efficacy of State programs on hereditary disorders. **DISAPPROVED**, unnecessary and duplicative. Current programs being sponsored by scientific and educational organizations appear adequate.

S-1390 Merlino—Medical Society of New Jersey

Permits the Medical Society of New Jersey to decide whether or not to extend representation within the House of Delegates to specialty societies. **ACTIVE SUPPORT**

S-1434 Scardino—Research of Efficacy of Schedule 1 substances

Permits research projects on the therapeutic effect of Schedule 1 drugs in conformity with Federal Law. **APPROVED**

S-1517 Wallwork—Professional Boards & Commissions

Amends existing law to provide that the Governor may suspend any public member of a given board who is under investigation for misconduct, incompetency, neglect of duty or other sufficient cause and appoint a successor therefor.

Additionally, the Governor must remove any professional members from the given board, who have had their license suspended or revoked or have been reprimanded or fined for improper conduct under *N.J.S.A. 45:1-14* (Professional Boards Act), *N.J.S.A. 45:1-1* (Real Estate Brokers and Salesmen), or *N.J.S.A. 45:24-1* (X-ray Technicians). **APPROVED**

S-1538 Vreeland—Psychiatric Hospitals

Permits a state hospital to designate a maximum security area for patients being evaluated or observed pursuant to temporary commitment order. **DISAPPROVED**, current provisions are adequate in the State Mental Hospitals for the patient population. In the case of criminal detention and observation, consultation can be provided at the jail site which is better equipped to provide maximum security.

S-1540 Skevin—Controlled Dangerous Substances

Grants to the Department of Health the ability to regulate and control the therapeutic research of marijuana in conformity with the Federal Drug Enforcement Administration (FDEA), Federal Drug Administration (FDA), and National Institute on Drug Abuse Protocol. **APPROVED**

S-1542 Russo—Civil Commitments

This bill would incorporate current Court Rules regarding review of civil commitments into statutory language and attempt to limit review to mental illness and potential danger to self or others. Theoretically, this would preclude discussions of medications, placements, and treatment modalities. (Practically, it would not achieve the result indicated.) **NO ACTION**

S-1557 Merlino—Workers' Compensation

Increases medical witness fees under workmen's compensation to \$250 maximum per individual and \$750 maximum in aggregate. **ACTIVE SUPPORT**

S-1578 Gagliano—(DRG) Diagnosis Related Group

The purpose of this bill is to postpone the implementation of the second phase of the diagnosis related group (DRG) health care cost program established under P.L. 1978, c. 83. **ACTIVE SUPPORT**

S-1587 DiFrancesco—Health Care Facilities

This bill proposes to amend *N.J.S.A. 26:21-1* et seq. to require the Health Care Facilities Financing Authority to secure legislative approval prior to authorizing the termination of emergency or acute care services in a given hospital. (Note: this is really the statutory obligation of the HCAB.) **APPROVED**

S-1593 Hamilton—Group Health Insurance

Would allow health insurers to compensate marriage counselors acting within the scope of their license. **DISAPPROVED**, because marriage counseling is a social service, not a medical service.

SR-35 Hagedorn—Hospices

Requests the Commissioner of Health to delay for sixty days the adoption of a Manual of Standards of Hospices to permit further study. **NO ACTION**

A-229 Huhler—Nuisance Suits

Allows reasonable attorney fees to successful defendants in the case of any frivolous claims. (Note—this also includes cross claims, third-party complaints, and counter claims.) **CONDITIONAL APPROVAL**, provided the bill is amended to delete the "frivolous" and to include the provision that "the prevailing party, as a matter of law, be awarded all court costs and legal fees."

A-1613 Fortunato—Treatment of Compulsive Gamblers

Requires the Department of Health to establish and advertise a treatment center for compulsive gamblers and to solicit grant funds for the establishment and operation thereof. The Commission shall submit operational and fiscal reports to the Legislature on an annual basis. **APPROVED**

A-1840 Franks—Administrative Procedure Act Amendment

There are three principal benefits to this legislation. First, it will force the agencies and departments of state government to conduct more thorough analyses of the costs of proposed administrative actions. Secondly, it would afford all parties directly affected by the proposed actions the opportunity to present fiscal information and recommendations to the agency. Finally, this bill would alert the legislature to the possible costs of the proposed action. **ACTIVE SUPPORT**

A-1881 Fortunato—Patient Profile Record

This bill would repeal the patient profile regulation of the Board of Pharmacy and preclude pharmacists from collection of medical history and medication data. **ACTION DEFERRED**, pending further information

from the Pharmaceutical Society of New Jersey.

A-1913 Brown—Smoking

Requires health care facilities to set aside not less than 30 percent nor more than 50 percent of total patient rooms as "no smoking allowed" rooms. **DISAPPROVED**, in favor of Assembly Bills 1725 and 1726.

A-1940 Bassano—Nursing Homes

Requires nursing homes to hold in reserve a Medicaid bed for fourteen days when the patient is transferred to a general hospital.

ACTIVE SUPPORT

A-1946 Bate—Organ Removal

Permits physicians performing mandated autopsies to remove pituitary glands unless a contrary indication was previously given by the decedent or is declared by the next of kin.

ACTIVE SUPPORT

A-2135 Burgio—Optometry

Provides that an optometrist who discovers any non-refractive eye disease or disorder must advise the patient, in writing, to seek medical attention. **CONDITIONAL APPROVAL**, pending deletion of the words "in writing".

A-2168 Gluck—Patient Rights

This proposal would effect a statutory bill of rights for patients in general hospitals. It adds nothing to existing common law except detailed procedure.

It provides that every person admitted to a general hospital shall have the right:

- To considerate and respectful care;
- To be informed, upon request, of the name of the physician responsible for coordinating his care;
- To obtain from the physician complete, current information concerning his diagnosis, treatment, and prognosis in terms he can reasonably be expected to understand. When it is not medically advisable to give this information to the patient, it shall be made available to another person on his behalf;
- To receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment and which, except for those emergency situations not requiring an informed consent, shall include as a minimum the specific procedure or treatment, the medically significant risks involved, and the possible duration of incapacitation, if any. The patient shall be advised of any medically significant alternatives for care or treatment;
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of this action;
- To privacy to the extent consistent with providing adequate medical care to the patient. This shall not preclude discussion of a patient's case or examination of a patient by appropriate health care personnel;
- To privacy and confidentiality of all records pertaining to his treatment, except as otherwise provided by law or third-party payment contract;
- To expect that within its capacity, the hospital will make reasonable response to his request for services;
- To be informed by the physician of any continuing health care requirements which may follow discharge;
- To be informed by the hospital of the necessity of transfer to another facility prior to the transfer and of any alternatives to it which may exist;
- To be informed, upon request, of other

health care and educational institutions that the hospital has authorized to participate in his treatment;

l. To be advised if the hospital proposes to engage in or perform human research or experimentation and to refuse to participate in these projects;

m. To examine and receive an explanation of his bill regardless of source of payment;

n. To be advised of the hospital rules and regulations that apply to his conduct as a patient; and,

o. To treat without discrimination as to race, age, religion, sex, national origin, or source of payment. **APPROVED**

A-2169 Stewart—Physical Therapists

This bill provides that physical therapists may deliver their services at the direction of licensed dentists. **NO ACTION**

A-2219 Bate—Confidential Communication

Makes it a disorderly persons' offense for a physician to disclose a confidential communication to someone not involved in the care of the patient unless the communication is necessary for the physician or nurse to receive payment for his/her services. **CONDITIONAL APPROVAL**, pending clarification of the vague language of the bill.

A-2232 Kavanagh—Health Care Facilities

This bill proposes to amend *N.J.S.A. 26:21-1* et seq. to require the Health Care Facilities Financing Authority to secure legislative approval prior to authorizing the termination of emergency or acute care services in a given hospital. (Note: this is really the statutory obligation of the HCAB.) **APPROVED**

A-2324 Burstein—Professional Liability Insurance

Grants the Malpractice Reinsurance Association perpetual operation. **APPROVED**

A-2252 Mays—Health Planning

Would prevent state officials from eliminating a hospital service unless it has been demonstrated that the hospital service constitutes a hazard to the public health. **APPROVED**

AMA Interim Meeting . . . Received as informative a report of the highlights of the 1980 Interim Meeting of the AMA House of Delegates held in San Francisco, December 7 to 10, and noted that the AMA plans to consider a dues' increase at the 1981 Annual Meeting.

Committee on Publication . . . Noted that the name of the Manuscript Review Board has been changed to the Editorial Board, and the following recently had been added to the list of members: Robert M. MacMillan, M.D., Geobel A. Marin, M.D., Bernard A. Rineberg, M.D., and Robert B. Zufall, M.D.

. . . Noted also that the Committee on Publication is planning a special meeting with members of the Editorial Board, specific MSNJ department heads and *The Journal* staff.

Microfilming the Society's Transactions

. . . Approved a recommendation that the Board of Trustees appropriate

\$4,604 for microfilming the *Transactions* of the Medical Society of New Jersey from 1766 through 1903, and *The Journal*, MSNJ, from 1904 through 1972 (since that date each issue of *The Journal* is microfilmed by University Microfilms International).

Nominating Committee Procedure . . . Requested the Committee on Revision of Constitution and Bylaws to review the present procedure of the Nominating Committee under which no candidate will be considered unless a curriculum vitae is available to the Nominating Committee.

Note: At the recent meeting of the Nominating Committee, one candidate seeking office failed to submit his curriculum vitae, and in another instance one of the incumbents had resigned and no candidates were proposed by the component societies. Under the Bylaw requirements, the Nominating Committee was unable to propose a candidate.

Ad Hoc Committee on Drug and Alcohol Abuse . . . Approved a recommendation that a letter be sent to the Governor requesting the appointment of a study group to investigate the problems of prescription drug misuse, abuse and diversion.

Reevaluation of the Functions of the Advisory Committee to the Auxiliary . . . Approved the following recommended activities as designated functions for the Advisory Committee to the Auxiliary as outlined by the Special Committee on Long Range Planning and Development:

a. **Coordinate programs of the Auxiliary with programs of the Medical Society of New Jersey** . . . The Auxiliary re-evaluates its activities each year and submits a schedule of programs to the Board of Trustees for approval.

b. **Assist in Auxiliary resource planning** . . . A budget is developed each year by the Auxiliary in conjunction with the Medical Society of New Jersey staff. The budget is funded by Auxiliary dues and by funds allocated for the Auxiliary in the Society's budget.

c. **Act as liaison for Auxiliary activities which need Society support** . . . mailings, printing, and so on.

d. **Provide Advisory Committee representation at meetings of the Auxiliary Board** . . . It was suggested that the Advisory Committee attempt to have a member present at the meetings of the Auxiliary Board (and other significant meetings at the state level). The Auxiliary Board meets four times yearly, at the Medical Society headquarters.

e. **Submit quarterly reports to the Board of Trustees on Auxiliary activities** . . . The establishment of an active liaison with the Auxiliary would initiate reports on attendance at Auxiliary Board meetings.

f. **Establish subcommittees with the Auxiliary** . . . A joint effort was suggested in planning specific tasks to maximize the Auxiliary's effectiveness. Areas to be considered would include long range planning, programming, membership, and political activities.

. . . Approved the following recommendation from the Special Committee on Long Range Planning and Development:

That the Board of Trustees approve the introduction of a Bylaw change to include the appointment of one member of the Auxiliary to each administrative council and committee of the Medical Society of New Jersey and that county medical societies be encouraged to take similar action at the county level.

. . . Approved the following recommendations concerning Auxiliary members' activities in county medical society affairs.

(1) That component societies explore the concept of inviting members of the county auxiliaries to attend their council, committee and regular meetings. (Underscore indicates amendment by the Board of Trustees.)

(2) That component societies explore the concept of appointing Auxiliary members to serve as representatives of their societies at meetings of various regional, county, state and political groups.

Note: The Committee on Long Range Planning and Development noted that designating Auxiliary members to act in various capacities established an opportunity for their involvement in a meaningful role and would provide a feeling of accomplishment. It is a means of using the talents of educated individuals and may be a mechanism to attract more spouses to join the Auxiliary.

. . . Deferred action on a suggestion on Auxiliary representation in MSNJ's House of Delegates.

. . . Noted the following suggested additional activities of the Auxiliary:

a. Attendance at MSNJ council and committee meetings (Mr. Maressa will discuss the possibility with the chairman of the Committee on Impaired Physicians).

b. Further emphasis with respect to legislation and political matters.

c. Assistance in research projects.

d. Articles in MSNJ's *Journal*.

e. Establishment of liaison with hospital auxiliaries.

f. Organization of future physicians' clubs, as a steering committee for interns and residents and a program for "future spouses." (The latter three were considered internal matters and were referred to the Auxiliary Committee for consideration.)

Medical Students and Residents on Councils and Committees . . . Approved a proposal calling for consideration of the appointment of medical students and residents to the administrative councils and committees.

Evaluation of the Medical Society of New Jersey . . . Took the following actions on recommendations of the Special Committee on Long Range Planning and Development who considered the evaluation report of MSNJ by the American Society of Association Executives:

1. Criterion I—Purposes, Goals, and Objectives

a. That the Board of Trustees charge itself and all councils and committees with the task of developing a yearly list of specific goals and objectives, and conducting a periodic review of their progress.

Approved by the Board.

2. Criterion II—Governing Body, Officers and Directors

a. That no change be made in the terms of offices of the officers and members of the Board.

Approved by the Board.

b. That the Nominating Committee be directed to evaluate objectively the candidates for leadership positions in the Society from the standpoint of ability, leadership capabilities, past performances, and effective actions.

Approved by the Board.

c. That the Board of Trustees meet every other month and that the Executive Committee meet, if necessary, in the month the Board is not meeting.

Disapproved by the Board in view of MSNJ's policy to open lines of communication between the State Society and the membership and the volume of business before the Board each month.

d. That the headquarters office become more involved in implementing activities while the committees set policy. The elected leadership would do well to make better use of the abilities which the state offers for implementing activities.

Endorsed by the Board.

e. That an orientation program be developed for the Board of Trustees and the committees at the start of each year to assist the elected leadership in setting goals and policies and in maximizing their talent and use of time.

Endorsed by the Board.

f. That the selection of elected leadership be reevaluated by the Long Range Planning Committee in order to make it possible for the membership of the organization to have more input into the selection of its officers, directors and committee chairmen.

The Long Range Planning Committee agreed with the concept but questioned its implementation and withheld any recommendation until an investigation is made.

g. That the staff develop a manual which lists policy decisions made by the Board of Trustees and the House of Delegates over the past five years.

Note: The manual is being developed and should be completed early this year.

3. Criterion III—Organization Structure and Documents

a. That thought be given by the Society to reducing the size and number of organizational structures in the Medical Society.

The Committee on Long Range Planning noted that this is carried out on an ongoing basis.

b. That the Board of Trustees approve the concept of limiting the House of Delegates to 300, as formerly proposed by the Committee on Long Range Planning and Development.

Approved by the Board by a vote of eight to seven.

Note: A previous recommendation from the Committee on Long Range Planning and Development to reduce the number of elected delegates was not adopted by the 1980 House of Delegates.

c. That guidelines be established to govern the scope of topics to be considered by the House.

Approved by the Board.

d. That the President assume the role of Speaker of the House of Delegates and the present posts of Speaker and Vice-Speaker be converted to Parliamentarian and Vice-Parliamentarian, with the understanding that the President would have the option to use their services in the event circumstances prevent him from functioning in the designated role.

Disapproved by the Board since current Bylaws provide for the President to des-

ignate whomever he chooses as Speaker, including himself.

e. That the present reference committee structure be continued.

Approved by the Board.

Note: The evaluation report recommendation to eliminate reference committees was not favored by the Committee on Long Range Planning and Development.

f. That the evaluation of councils and committees continue to be a function of the Board of Trustees in conjunction with the staff of the Medical Society of New Jersey.

Approved by the Board.

Note: This is an ongoing process conducted at the beginning of each administrative year and committees of a temporary nature are discontinued on completion of the assignment.

g. That a survey qualified to produce a defined result be conducted to determine whether the membership would be in favor of a mail ballot vote: (1) to elect officers; (2) to adopt major policy of the Society; and (3) to amend Bylaws.

Approved by the Board.

h. That the governing groups decide what policies and course of action the Society should follow and the Executive Director and staff implement these policies, and that the distinction between the policy-making bodies and the implementing executive office should be made clearer than it presently is.

The Long Range Planning Committee noted that this concept already has been accomplished.

4. Criterion IV—Programs, Services and Activities

Nothing was recommended under this criterion that is not currently in effect and/or covered previously in this report.

5. Criterion V—Association Staff

a. A recommendation to improve communications within the executive office and meetings with department heads and key personnel for establishing the next year's program and budget has been noted by the staff.

b. Recommended administrative and personnel procedures were either currently in effect or being developed before this report was issued and thus no action was necessary by the Board.

6. Criterion VI—Financial Planning and Reporting

a. A recommendation that the State Society bill and collect all dues and send to the county societies their portion previously had been recommended, but the concept was not approved, thus the Committee on Long Range Planning and Development took no action.

b. A recommendation of the evaluation team that the Bylaws be streamlined in the areas of financial management, budget development, administrative operations and fiscal control was felt to have been accomplished and no action was recommended by the Committee on Long Range Planning and Development.

c. Other recommendations for streamlining financial procedures either already were in effect or under consideration and no action was necessary.

7. Criterion VII—Membership Development and Retention

Recommendations of the evaluation team already had been taken under consideration and previously acted upon by the Committee on Long Range Planning and Development, thus no further action was taken.

8. Criterion VIII—Communications

a. That no change be made in the current operation of the MSNJ *Journal* and that the publication of the *Membership Newsletter* remain as a joint effort of the staff and the Council on Public Relations.

Approved by the Board.

b. A recommendation to obtain inhouse typesetting had been investigated thoroughly and was considered not practical.

c. A recommendation for regular meetings with the executive directors of the county medical societies already had been implemented.

d. A recommendation for the establishment of closer relationships with the medical specialty societies through representation in the House of Delegates was already under consideration and preliminary steps had been taken to effect a determination by the House regarding the concept.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

The following is an address by Stanley S. Bergen, Jr., M.D., President, CMDNJ, delivered to the New Jersey Legislature on February 19, 1981, on the occasion of the tenth anniversary of the College of Medicine and Dentistry.

It is an honor and a pleasure to appear before you today. As a native son of New Jersey, this is a highlight of my life on two counts: It is always a mark of personal privilege to address the Legislature of your home State. And second, it gives me the opportunity to thank you personally and give public recognition to your commitment to the College of Medicine and Dentistry of New Jersey.

I come to you as we celebrate the completion of our first decade. Over the last few months, we have been working to make the State aware of our gratitude for its continuing support, through a series of scientific symposia, seminars and lectures and culminating in a gala anniversary celebration in mid-November which brought together people and groups from all walks of life. Also, we have published a *Journal* which looks to our first ten years as well as to our future. You will be receiving a copy of this publication today.

We are finding, however, that our efforts require continuous reinforcement since New Jerseyans are curiously reticent toward self-congratulation. As a medical educator and administrator who has been able to compare New Jersey's experience with that of other states, I can say that you and your constituents have a right to be proud of the institution you have created. CMDNJ's success in its first ten years has been phenomenal, and its accomplishments are your accomplishments. Only because of the progressive policies of our State government and the constant support of the people of New Jersey can I address you today looking optimistically toward the future of our institution and its ever-growing contribution to improved health care for all the people of the State.

Let me begin by pointing out that an institution such as CMDNJ, which provides all the medical education and virtually all the health professions' education in the state, though not unique is rare. In placing these responsibilities in a single university, you have set forth an institution which embodies a concept

that other states are beginning to endorse.

CMDNJ has undergone impressive growth during its first decade. Today, it includes six educational units: three medical schools, a dental school, a graduate school of the life sciences and a school of allied health. Two thousand students are now enrolled in its programs—a three-fold increase since 1970—and more than one thousand interns and residents receive their graduate education in our training programs. We employ a work force of six thousand people, making us one of the largest employers in the State of New Jersey. Our scientists and clinicians perform over 10 million dollars of research annually, which places us among the top 100 recipients of federal research dollars among all institutions of higher education in the country.

The College occupies three sites with its own facilities. At Newark, our major campus consists of the CMDNJ-New Jersey Medical School, the CMDNJ-New Jersey Dental School, the CMDNJ-School of Allied Health Professions, the CMDNJ-Graduate School of Biomedical Sciences, a community health center and our primary teaching facility, CMDNJ-College Hospital. Our campus at Piscataway near New Brunswick comprises the CMDNJ-Rutgers Medical School, part of the teaching program of the CMDNJ-New Jersey School of Osteopathic Medicine and a community mental health center. In the Camden/Stratford area in South Jersey both the osteopathic and allopathic medical schools offer training to students in their third and fourth years and we are beginning construction of a major facility as a single base for both clinical teaching programs.

But the uniqueness of CMDNJ lies in its scope beyond education. Throughout the State, we enmesh instruction, research and service to serve the needs of predominantly urban communities, while at the same time producing our own revenue to assist in the provision of these services. CMDNJ has set new precedents by joining with strong voluntary hospitals such as the Middlesex General Hospital in New Brunswick, the Cooper Medical Center in Camden, and the John F. Kennedy Medical Center in Stratford, to serve as our core teaching facilities.

In addition, our affiliations extend to more than 60 health care institutions in New Jersey. These hospitals provide teaching opportunities for medical, dental and allied health students and resi-

dents. In return, our education programs help enhance patient care and services at these institutions.

Both through these linkages with hospitals as well as cooperative and joint programs with 15 higher educational institutions, we have implemented the State's mandate to avoid duplication of resources already available. Our institutional coworkers are the county colleges, the state colleges, Rutgers University, Stevens Institute of Technology, Seton Hall University, NJIT, and others where we jointly provide educational programs in medical technology, respiratory therapy, physical therapy, laboratory technology, physician assisting and many other health professions' programs. Representatives of State and national accrediting agencies visiting New Jersey are amazed at the unique nature of cooperation we have been able to develop with other institutions. An example of this cooperation is our agreement with Rutgers University to issue joint degrees at both the baccalaureate and graduate level.

As in all of our efforts, however, the true beneficiaries are the people of New Jersey. Although some authorities are predicting an over supply of physicians in the United States, this is not true for New Jersey. We still are working here to overcome two centuries of neglect. By basing our students in community hospitals throughout the State, we expose them to the needs and opportunities of various regions. By offering them a wide variety of residency programs, we provide them the opportunity to stay in New Jersey and render care to its citizens. Similarly, other programs we sponsor allow young New Jerseyans who have gone abroad for medical education to return home and complete their training. The end result is a sufficient supply of professionals to meet the needs of our citizens.

On another front, significant innovative bio-medical research is being conducted at the College. You know that quality research leads to quality medical care, which, in turn, leads to better health care delivery. To cite a few examples: a physician and a basic scientist, both of our Rutgers Medical School faculty, have joined to identify genetic abnormalities that involve sickle cell disease. An engineer and an orthopedic surgeon at our New Jersey Medical School are working on developing materials and procedures that might be used to replace damaged tendons that affect athletes and people hurt in accidents. We know more about physical pain through our Dental School pain center.

Some of our clinicians are working to develop various replacement prostheses for patients being operated on for cancer. Recently we have begun development of an extensive research-based education program in toxicology. This will allow us to attack many of the environmental problems of the State of New Jersey through applied research and improved techniques of health care.

We also have inaugurated a number of services and programs to help each and every citizen of the State of New Jersey. Our office of consumer health education, the first in the nation, teaches us about health services, provides patient information and helps to publicize health problems and means by which to deal with them.

The Advisory Council on Graduate Medical Education, jointly an agency of the College and Department of Higher Education works with both the Commissioner of Health and the Chancellor of Higher Education to review and advise upon a grants' program that stimulates the development of primary-care, family-medicine residencies in community hospitals throughout the state.

Our Library in Newark serves as the main repository of health information for the entire state; this facility is used by education, industry and professions alike. Our beginning involvement in television, cable television, continuing education and other media has provided a broad overview for many constituencies and represents an extensive interest of the College in providing a better informed public for the state.

An important linkage to our business community is provided through the Foundation of CMDNJ where many dedicated leaders of New Jersey industry serve on its Board. This group has generated a significant support system to provide funds for non-state-supported projects to stimulate initiative within our institution at the research, service, education and community program levels.

Through these education, research and service functions, CMDNJ enters the lives of most of our people at one point or another. We are a major revenue producer, and have a major economic impact upon the State. Our activities cut across the line of State departments, bureaus and agencies. In working with the Legislature and the executive branch as well, CMDNJ has come to belong to everyone—institutions and individuals.

It was the foresight and daring of the New Jersey State Legislature ten years ago which outlined for its new health

science university the unprecedented mission that would take CMDNJ far beyond the models evolved over centuries in other States. And it has been your continued support which has provided us with the means to fulfill this mission.

New Jersey has a huge investment in CMDNJ. Millions of dollars have been channeled into providing us with the capacity to establish and develop. But beyond mere financial backing, the College has been the beneficiary of the most dramatic outpouring of support and interest that New Jersey has ever seen. Both of these factors have been essential to its progress to date, and have served to nurture your institution through its developmental years. We owe a debt of gratitude to those at every level in the State who have made it possible for CMDNJ to survive and flourish.

CMDNJ has now come of age. New Jersey's protege has proved itself equal to the challenges you set forth, developing into an institution far more complex and sophisticated than we could have envisioned a decade ago. In short, CMDNJ has become a model among its peers.

As the institution has matured, its needs and concerns also have changed. With its major construction programs completed, the College no longer requires the large capital outlays of its early years. The extraordinary scrutiny and close control by so many branches of the State government which helped the College through the difficulties of its early years no longer may be appropriate.

The issues confronting CMDNJ as it enters its second decade are far different and much less obvious than those which faced us ten years ago. Yet, they are equally urgent, and the people of New Jersey, through you, their representatives, must understand and confront them, if they are to continue to receive an equitable return on their investment in health professions' education. We will strive to keep you, the elected state officials, aware of these issues.

Hopefully, these few remarks provide a glimpse as to the many ways that CMDNJ is fulfilling all of our hopes for success as an educational, health care delivery institution. But the College is more than that, too.

In carrying out its mission, the College has in fact become a network, a functioning system of health sciences and professions in education, research and services that establishes the uniqueness of CMDNJ in our state and

places us among the nation's leaders in identifying health as a major concern of the State of New Jersey.

This is your work and you should be proud of the results you have fostered. Come visit with us, meet our people, enjoy your accomplishments. As you do so, you will come to understand our programs and the uniqueness of what has been created.

We, the CMDNJ, must be responsive and attentive to the changes of the 1980's. Our organizational structure must have flexibility to help us heal the sick and alleviate pain. Institutional initiative begets institutional accountability. Effective response by our faculties and staffs to the needs of health sciences and professions' education and service requirements depends on institutional management and self-reliance on behalf of everyone's health needs in this state. With your help and understanding we will seek the adjustments required to reach these goals just as we have in the comparatively short time of ten years already surpassed even our most ambitious plans.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

Reference has been made many times in these pages to the concept of competition versus regulation in containing medical care costs. When this Foundation began to draw your attention to prepaid health care systems, competitive forces were cited as one reason for their spread to the East. Walter McClure, of InterStudy, spoke at our seminar at MSNJ's Annual Meeting in 1979. He challenged the audience to choose between more regulation or more competition. While there may be more than two options, the pendulum is beginning to move toward competition. National bodies are taking up the banner, in the hope that regulations will be reduced. The American Hospital Association voted for repeal of PSRO and for a gradual phaseout of the Health Planning law.¹ The delegates voiced their enthusiasm for concepts of consumer choice and free market competition. Some observers viewed this as a "stunning" reversal of AHA's previous attitudes.

This was a timely shift in posture, since it happens to coincide with the

projected desires of the Reagan Administration. Susan Fogg, Washington correspondent for Newhouse newspapers, wrote in *The Star-Ledger*: "Free market competition, rather than government regulation, is the Reagan Administration strategy for containing what many federal officials see as the budget-breaking costs of health care."² Developers of this strategy have been identified in this column previously—Secretary Schweiker of HHS, Director Stockman of OMB, Senator Durenberger, Representative Gephardt and others. They, in turn, have been listening to such strategists as Clark Havinghurst of Duke Law School and Professor Alain Enthoven of Stanford.

Enthoven's Consumer Choice Health Plan³ would require employers to offer at least three health packages to their workers. These would range from fee-for-service to health maintenance organizations. Premium costs and benefit packages would be determined by the marketplace (competition). The worker (consumer) will be free to choose the plan most beneficial to his family (consumer choice). Above a fixed premium level, workers would no longer get a tax-free subsidy, but would pay the difference, or arrange to have the employer pay it. This would eliminate the present system, whereby the employer writes off the whole premium cost, and the worker receives coverage as a fringe benefit. The various plans would compete for the premium dollars. Medicare and Medicaid subscribers would participate by cash vouchers supplied by the govern-

ment. Bills to this effect have been introduced by Senator Durenberger and Representative Gephardt (with Mr. Stockman's participation). Representative Rostenkowski, Chairman of the House Ways and Means Committee, is also favorably inclined to this method. Mr. Rostenkowski, as you will recall, challenged physicians and hospitals to control cost escalation via the voluntary effort, adding that he doubted that it could be done.

Congressional hearings and debate will indicate the next phases in development of this strategy. Industry and labor will be heard from, since both are interested in the effects of the Enthoven plan on their negotiations over benefit plans. The tax changes and decisions over who will pay the difference over the set premium should produce interesting arguments. Medicare and Medicaid involvement will require changes in rules governing these programs. Such changes will be promulgated by regulations. There also may be attempts to add catastrophic coverage to whatever plans emerge. Resulting laws will be implemented by the appropriate bureaucracies. Unless there is a complete change in the way government does business, such implementation will require regulations.

The advent of a new administration does not mean that no attention will be paid to costs of medical care. PSROs and HSAs may disappear, but some other bodies will review utilization, ancillary services, technology, and so forth. The use of alternative services (and alter-

native providers) will be promoted. Attention to quality will be minimal. There may be less regulatory pressure from Washington, but any gaps in surveillance may be filled by AFL-CIO and the industrial associations. AMA is increasing its dialogue with representatives of injury on containing the costs of their health care coverage. The American Association of Foundations for Medical Care (AFFMC) has been doing this for years.

Local government interests in health will not go away. Replacement of federal-state programs with block grants will put more regulatory power in the state departments of health and insurance. The President mentioned reduction in Medicaid participation in his budget message. Less federal funds will mean more pressure on state agencies to reduce services, costs, and fees.

Physicians will find themselves at the center of attention of all efforts to reduce costs. They may not be invited to participate in the new strategies, but they will be affected by them. New Jersey Foundation for Health Care Evaluation will continue to keep you informed. We remain convinced that no program to improve efficiency in medical care can succeed without professional peer review to preserve quality.

¹Hospital Week, American Hospital Association, February 6, 1981

²*The Star-Ledger* (Newark), February 22, 1981

³Enthoven, Alain C.: *Health Plan*. Reading, Massachusetts, Addison-Wesley Publ. Co., 1980

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Won S. Cho, M.D., 1303 Midmeadow Road, Towson, MD 21204. Korea University, 1963. Board eligible. Group, partnership, or solo. Available on one month's notice.

CARDIOLOGY—Lawrence J. Gessman, M.D., 21 Sabine Avenue, Narberth, PA 19072. University of Pennsylvania 1974. Board certified. Group, partnership (preferably with cardiac catheterization). Available.

G. R. Kolluru, M.D., 914 South Avenue, Apt. E-33, Secane, PA 19018. Andhra (India) 1973. Board certified (IM). Group, partnership, solo. Available July 1981.

FAMILY MEDICINE—Robin O. Winter, M.D., Hunterdon Medical Center, Flemington, NJ 08822. Einstein 1978. Board eligible. Group, partnership, solo. Available August/September 1981.

GASTROENTEROLOGY—George J. Rezk, M.D., 7713 Fort Hamilton Parkway, Brooklyn, NY 11228. Bologna (Italy) 1976. Board eligible. Group or partnership. Available July 1981.

GENERAL PRACTICE—Kirit J. Shah, M.D., 136 Thornhill Road, Cherry Hill, NJ 08003. S.S. Medical (India) 1970. Group or solo in community in need of a physician. Available.

HEMATOLOGY/ONCOLOGY—Frank

Gentile, M.D., 654 Dahill Road, Brooklyn, NY 11218. Bologna (Italy) 1972. Board eligible. Solo, group, associate, partner. Available July 1981.

INTERNAL MEDICINE—Modhi Gude, M.D., 210 Shippen Street, Weehawken, NJ 07087. Andhra Medical (India) 1968. Subspecialty endocrinology. Board certified. Group, partnership, or solo. Available July 1981.

Maria Del Rosario Gomez, M.D., 294 Thunder Circle, Bensalem, PA 19020. Madrid 1976. Board eligible. Group or partnership. Available July 1981.

Martin Lerman, M.D., 3258 Lauriston Place, Fairfax, Virginia 22030. Georgetown 1973. Board certified. Any type practice. Available.

Fayez A. Roumani, M.D., P.O. 522, Bradford, PA 16701. Damascus (Syria) 1973. Subspecialty, nephrology. Board eligible. Group or hospital-based. Available.

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

**Each CEREBRO-NICIN® capsule
contains:**

Pentylenetetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
l-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Steven Rosner, M.D., 150 Colton St., Apt. 3-D, Staten Island, NY 10305. New York Medical College 1976. Subspecialty, rheumatology. Board certified. Group, partnership. Available July 1981.

Robert J. Moran, M.D., 801 East 10th Street, Brooklyn, NY 11230. SUNY-Downstate 1977. Board eligible. Group, partnership, or hospital-based. Available July 1981.

Joseph A. Catapano, M.D., 298 Townhouse, Hershey, PA 17033. Rutgers 1976. Also, clinical cardiology. Board certified. Available July 1981.

William C. Zuck, Jr., M.D., 1769 Raleigh Court West, Apt. 25-B, Ocean, NJ 07712. Graz (Austria) 1977. Board eligible. Solo or group. Available July 1981.

Sanford L. Taffet, M.D., 160 East Hartsdale Avenue, Hartsdale, NY 10530. NYU 1976. Subspecialty, gastroenterology. Board certified. Partnership or group. Available July 1981.

Arvind M. Mehta M.D., #1-F. Bldg. 1, 40 Prospect Avenue, Norwalk, CT 06850. M.S. University (India) 1975. Subspecialty, cardiology. Board eligible. Group, partnership or multi-specialty group. Available July 1981.

John Aylward, M.D., 86 East Almira Street, Bloomfield, NJ 07003. CMDNJ 1978. Group or partnership. Available July 1981.

Vijay K. Nellore, M.D., 134 North Street, Bayonne, NJ 07002. Osmania (India) 1973. Solo, group, or institutional. Available July 1981.

Mark Isserman, M.D., 103 Dennis Avenue, Port Allegany, PA 16743. Jefferson 1977. Board certified. Solo, partnership, group. Available July 1981.

NEPHROLOGY—Krishnababu Chunduri, M.D., 2121 Shore Parkway, Apt. 2-F, Brooklyn, NY 11214. Guntur (India) 1973. Board eligible. Solo or group. Available.

Vijay K. Nellore, M.D., 134 North Street, Bayonne, NJ 07002. Osmania (India) 1973. Solo, group, or institutional. Available July 1981.

NUCLEAR MEDICINE—M. I. Straub, M.D., 254 Frances Street, Teaneck, NJ 07666. Semmelweis (Hungary). Special interest, diagnostic radiology. Board eligible. Available July 1981.

OBSTETRICS/GYNECOLOGY—Kailash R. Makhija, M.D., 5628 Fifth Avenue, Apt. B-10, Pittsburgh, PA 15232. GMC (Bombay, India) 1974. Board eligible. Group, partnership, solo, with coverage, suburban area. Available July 1981.

F. Adibi, M.D., 84 Skyline Drive, Chalfont, PA 18914. Tehran (Iran) 1967. Board certified. Group/partnership. Available.

Dilipkumar G. Patel, M.D., 72 Duke Street, New Brunswick, NJ 08901. Baroda (India) 1974. Board eligible. Group, associate, solo, hospital. Available July 1981.

OCCUPATIONAL MEDICINE—Louis Z. Fautoux, Jr., M.D., 294 Carlton Avenue, Piscataway, NJ 08854. Georgetown 1947. Board certified (IM). Industrial. Available.

PATHOLOGY—Sitamahalakshmi Nutakki, M.D., 22 Metropolitan Oval, #5G, Bronx, NY 10462. Guntur (India) 1970. Board eligible. Group or partnership. Available.

Meera V. Bodas, M.D., 4 Manitou Way, Scotch Plains, NJ 07076. Nagpur Medical (India) 1967. Board eligible (AP/CP). Group (part-time also acceptable). Available July 1981.

Shokat Fattgh, M.D., 260 First Street, Mineola, NY 11501. Baroda (India) 1975. Board certified. Any type practice. Available May 1981.

Alexander J. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified (AP and CP). Any type practice including institutional. Available June 1981.

PEDIATRICS—Anil G. Pradhan, M.D., 118 Grove Park, Fort Dix, NJ 08640. Bombay (India) 1972. Board certified. Solo, partnership, associate, group. Available.

Rajendra C. Parikh, M.D., 77-07 Woodside Avenue, Apt. 3-A, Elmhurst, NY 11373. Baroda (India) 1975. Board eligible. Group, partnership, solo, or institutional. Available June 1981.

Shara J. Doshi, M.D., 304 Fir Street, Raceland, Louisiana 70394. B.J. Medical (India) 1969. Board eligible. Solo, group, partnership, clinic. Available.

Fe C. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified. Any type practice. Available June 1981.

Yogesh J. Pandya, M.D., 24 Puerdeg—15th Street, Brooklyn, NY 11236. Baroda (India) 1973. Board eligible. Solo, group, partnership, hospital-based. Available.

PSYCHIATRY—Florence Ouseph, M.D., 2200 South Rock Road, Apt. 1108, Wichita, Kansas 67207. Christian Medical (Vellore, India) 1975. Board eligible. Institution (VA Medical Center). Available November 1981.

RADIOLOGY—U. Chaibongsai, M.D., 992 Woodmere Drive, Westfield, NJ 07090. Siriraj (Thailand) 1968. Board certified. Part-time, group, partnership. Available.

Indu M. Solanki, M.D., 266 Beaufort Avenue, Livingston, NJ 07039. B.J. Medical (India) 1967. Board certified. Solo, group, or partnership. Available.

Sita V. Krishnaswamy, M.D., 1735 Haight Avenue, Bronx, NY 10461. Grant Medical College (India) 1972. Emphasis on therapeutic radiology. Board eligible. Any type independent practice or partnership. Available July 1981.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379. Shah (India) 1969. General practice and rehabilitation medicine. Available on three months' notice.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available July 1981.

Thomas A. Giangrasso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Can-

A peripheral vasodilator
for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN[®]
Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN[®]/300 mg.

Each time-release capsule contains:

Nicotinic Acid	.....	300 mg.
Ascorbic Acid	.....	150 mg.
Thiamine HCL (B-1)	.....	25 mg.
Riboflavin (B-2)	.....	2 mg.
Pyridoxine HCL (B-6)	.....	10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN[®]/250 mg.

Each yellow tablet contains:

Nicotinic Acid	.....	250 mg.
Niacinamide	.....	75 mg.
Ascorbic Acid	.....	150 mg.
Thiamine HCL (B-1)	.....	25 mg.
Riboflavin (B-2)	.....	2 mg.
Pyridoxine HCL (B-6)	.....	10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN[®]/100 mg.

Each blue tablet contains:

Nicotinic Acid	.....	100 mg.
Niacinamide	.....	75 mg.
Ascorbic Acid	.....	150 mg.
Thiamine HCL (B-1)	.....	25 mg.
Riboflavin (B-2)	.....	2 mg.
Pyridoxine HCL (B-6)	.....	10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN[®] 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



ada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available July 1981.

SURGERY, GENERAL—Zahur U. Azhar, M.D., 1684 Central Avenue, Bridgeport, CT 06610. Nishtar (Pakistan) 1963. Board eligible. Solo. Available July 1981.

Dariush Vaziri, M.D., 7510 Brompton Court, Apt. 587, Houston, TX. Tehran (Iran) 1974. Also, vascular surgery. Board eligible. Group, partnership. Available August 1981.

Carlos A. Viola, M.D., Avenida Cordoba 77 Oeste, San Juan 5400, Argentina, South America. National University, Buenos Aires 1950. Also, general medicine. Institutional, group, or partnership. Available.

S. W. Choi, M.D., 14 Phyllis Place, Milltown, NJ 08850. Seoul (Korea) 1967. Board certified. Group or partnership. Available.

Jawaid Akhtar, M.D., 21634 Stratford Court, Oakpark, MI 48237. Karachi (Pakistan) 1967. Also, colon and rectal surgery. Board certified (general and colon and rectal). Solo, group, partnership, or associate. Available.

Ruben J. Delgado, M.D., 293 First Street, Mineola, NY 11501. Puerto Rico 1976. Also, vascular surgery. Board eligible. Group or partnership. Available July 1982.

Bijoy Bhushon Sarmaroy, M.D., 631 East 235th Street, New York, NY 10466. Assam Medical (India) 1968. Group, partnership, solo. Available July 1981.

Mohammad Qubair, M.D., 2694 South Hoyt Street, Lakewood, CO 80227. Pakistan 1970. Board eligible. Partnership, solo. Available July 1981.

Jin-Young Lee, M.D., St. Mary's Hospital, 56 Franklin Street, Waterbury, CT 06702. Seoul National (Korea) 1971. Board eligible. Group, partnership, solo. Available July 1981.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available July 1981.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available July 1981.

Inder J. Singh, M.D., WCMC #1-C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available July 1981.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available July 1981.

SURGERY, VASCULAR—Pramod. Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available June 1981.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo,

partnership, group. Available July 1981.

UROLOGY—Elliott Lieberman, M.D., 16-66 Bell Boulevard, Apt. 730, Bayside, NY 11360. SUNY-Downstate 1976. Group or partnership. Available July 1981.

William Kohlberg, M.D., 3450-17A Wayne Avenue, Bronx, NY 10467. Pittsburgh 1975. Board eligible. Group or partnership. Available July 1981.

Paul A. Church, M.D., 435 East 70th Street, Apt. 27-C, New York, NY 10021. Cornell 1975. Board eligible. Solo, partnership, group. Available June 1981.

Vasant Betkerur, M.D., 10015 South Hill Terrace, 28/202, Palos Hill, IL 60465. Government Medical (India) 1973. Solo, partnership, group. Available July 1981.

Harvey Schoenbrum, M.D., 1249 Park Avenue, Apt. 14-A, New York, NY 10029. Pittsburgh 1976. Board eligible. Group, partnership. Available July 1981.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available June 1981.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available July 1981.

Robert D. Zimmerman, M.D., 206 Friar Lane, Clifton, NJ 07013. Chicago Rush-Presbyterian. Board eligible. Partnership, solo, group. Available July 1981.

LETTERS TO THE JOURNAL

Cerebral Concussion

January 27, 1981

Dear Dr. Krosnick:

With a realization that articles reporting on the management of large case series provide some of the basis for accepted standards of care in the community, I feel obliged to respond to the recommendations set forth by Drs. Maio and Dwyer in the article "Cerebral Concussion: An Area Wide Survey of Clinical Experience with 467 Cases," *J Med Soc NJ* 77:637-641 (Sept) 1980.

The article documented extensive and at times unnecessary use of ancillary diagnostic tests while slightly more than half of the concussion patients were not seen by a neurologist. The summary

states, "On the basis of minimal treatment recorded and the small percentage of the retrospective group with persisting signs and symptoms, it appears that the health dollar expenditure for this type of patient might be reduced without sacrificing quality of care by hospitalizing them for less than twenty four hours and structuring a neurological consultation and a skull x-ray series into the observation process."

In my view there is no justification in the sweeping recommendation that a neurological consultation be obtained on every patient with concussion when admittedly the large majority of these patients require minimal treatment and few have persisting signs or symptoms. Aside from the exorbitant expenditure

of a neurologist's time in the management of cases which can be handled adequately by the attending physician the health dollar expenditure is certainly not reduced by adding a neurologist's consultation fee to the cost. In terms of medical effectiveness I am certain that most neurologists would agree that, given a patient with a concussion who has little or minimal symptoms and is found to be relatively intact by the attending physician, the neurologist is not at all likely to find abnormalities on his examination which would suggest the presence of a potentially serious complication.

I feel that the answer is not to utilize a neurologist in place of ancillary tests but to improve the educational level of the

attending physicians with regard to the management of head injuries so that they do not order ancillary tests unnecessarily.

I feel that the summary of the article should have stated that based upon the studies the patient who has brief loss of consciousness due to head injury but with little or no residual symptoms and no objective findings during a twenty-four hour period of observation should not undergo any neuro-diagnostic tests except for skull x-ray. If the patient remains symptomatic after twenty-four hours then a neurological consultation would be justified not only for an estimate of prognosis but for the purpose of deciding what ancillary tests might be of value. With this type of conclusion the neurologist will not be called upon to see every minor concussion in a hospital and the attending physician will be given the clear responsibility of being prudent in ordering laboratory tests for his patients.

I believe that this recommendation, if carried out, would still provide room for cost containment without placing a medico-legal burden on the attending physician by requiring a neurological consultation in every case.

(signed) H. Louis Chodosh, M.D.

Medical Inter-Insurance Exchange

January 26, 1981

Sirs:

I am a physician, a member of our state society, no longer in private practice but working in a hospital on a part-time basis. I am a member of the Medical Inter-Insurance Exchange and want to bring to the attention of the New Jersey medical community what I perceive to be a great injustice to myself and to over 200 similarly situated N.J. physicians who are members of the Medical

Inter-Insurance Exchange.

I joined the exchange as a charter member in 1977 and advanced several thousand dollars to help establish the organization. When I left private practice my malpractice insurance was provided by my hospital through another company and I requested return of the original seed money. This was refused on the grounds that I had signed the original agreement that the money would not be refunded except in case of death, retirement or leaving the state. I am now in the position of having my money in the hands of the Medical Inter-Insurance Exchange which provides me with neither service nor any return on the money.

Two letters to Commissioner Sheeran of the State Insurance Department have failed to elicit the courtesy of a reply.

I bring this matter to the attention of the readership of this *Journal* in the hope that other doctors in my predicament will contact me so that we can join together to seek remedial action and to alert the medical community of New Jersey to a serious inequity which is being perpetrated on many of their fellow physicians.

(signed) Leon J. Anson, M.D.

Transluminal Angioplasty

February 19, 1981

Dear Dr. Krosnick:

The editorial entitled "Grüntzig's Plaque Pressing: Verbum Sapienti" by J. Alpert in Vol. 78, No. 2, February 1981, p. 87, raises several questions which need reply.

Let us not lose sight of the principal issue which is what is best for the patient. Just as surgery is a controlled injury so is percutaneous transluminal angioplasty (PTA). I agree with the need for the involvement of vascular surgeons in a consultative manner, as well as

internists interested in vascular disease when a patient is identified as a possible candidate for PTA. I also would urge the vascular surgeons to become familiar with the literature on PTA which now is reaching floodtide proportions.¹ I'm sure hospital administrators would agree that a 72-hour admission for a successful PTA is considerably less than the average admission for surgical reconstruction of the same vessels. It would seem from our initial experience,² that PTA of the renal artery for renovascular hypertension is now becoming the mode of therapy because of the mortality rate reported up to 5.9 percent surgically.³

I do agree with Dr. Alpert's plea not to grant transluminal dilatation privileges to anyone not trained in angiography. The technique requires considerable manipulation using all the "tricks of the trade." Early results, up to three years, now are being reported in patency rates for the iliac and femoral vessels which appear to be about the same as for surgical reconstruction. Although time will be the truest judge of which technique is better, I do believe that the techniques are not competitive and the awareness of the general public will certainly increase the pool of patients who will be referred to either surgical treatment or PTA. I strongly disagree that PTA is investigative and I would point out that third-party carriers have recognized this fact. The only exception to the rule of reimbursement is for procedures done in the coronary tree at this time.

Perhaps, the greatest advantage of PTA will come in the future since at this time, we know that it is repeatable.

(signed) Richard J. Byrne, M.D.

¹Symposium on Transluminal Angioplasty *Am J Radiol* 135:891-1000, (Nov) 1980.

²Byrne RJ: Renal angioplasty for hypertension in a community hospital. In Press.

³Foster JH, Maxwell MN, Franklin SS: Renal vascular occlusive disease. Results of operative management. *JAMA*: 231:1043-1048, 1975.

SYMPOSIUM ON ASTHMA SATURDAY, JUNE 6, 1981



Department of Medicine,
College of Medicine and
Dentistry of New Jersey —
New Jersey Medical School

Topics:

Immunopathogenesis, Respiratory Control and Respiratory Muscle Function, Lung Sounds and Objective Monitoring, Occupational Asthma and Management of Asthma with a practical use of various classes of drugs for the asthmatic.

Faculty:

Drs. F. Chinard, NJMS; B. Cohen, Elizabeth General Hospital; R. George, U. of Louisiana; M. Laviets, NJMS; R. Loudon, U. of Cincinnati; L. Reichman, NJMS; H. Reynolds, Yale U. School of Medicine; D. Rochester, U. of Virginia; C. Shim, Albert Einstein College of Medicine; V. Taraska, U. of Manitoba Faculty of Medicine; H. Weill, Tulane U. Medical School.

Fee: \$40.00

For Registration Information:

Please contact Pat Sarles, M.S., CMDNJ-Continuing Education, 100 Bergen St., Newark, NJ 07101 (201) 456-4267.

Wills Eye Hospital

**Ophthalmology for the
Family Medicine / General Practice Physician**

Topics to Include:

Practical Anatomy and Physiology
Corneal Foreign Bodies, Abrasions, Chemical Burns
Contusive and Penetrating Injuries
Management of the Red Eye

Steroids and Ocular Disease
Glaucoma for the Non-Ophthalmologist
Ocular Complications in Systemic Drug Therapy
Recent Advances in Cataract Treatment

Richard A. Ellis, M.D., Course Director

Place:

Wills Eye Hospital
Main Auditorium
9th & Walnut Streets
Philadelphia, PA 19107

Time:

Wednesday, May 6, 1981
10:00 A.M. to 3:00 P.M.

Fee:

NO CHARGE

CME Credits:

M.D. and D.O.

INFORMATION AND REGISTRATION:

Department of Continuing Medical Education
Wills Eye Hospital

Ms. Lucia M. Manes

(215) 928-3258

Christian Health Care Center

...since 1911

Wyckoff, New Jersey

07481

301 Sicomac Avenue • (201) 427-2816

A private facility which offers the following services:

INPATIENT PSYCHIATRIC SERVICE

- 81 bed facility for continued care (primarily psychiatric-geriatric)
- 14 bed short term unit for women over 18 years of age

OUTPATIENT PSYCHIATRIC SERVICE

- Serving all ages with psychiatric and counselling services
- Continuing care and supervision for patients

Fully accredited by Joint Commission of the Accreditation of Hospitals.

Able to accept either voluntary or involuntary patients.

For further information regarding admission, write or call Admission Office



CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

May

- 13 **Metabolism of Anesthetic Agents**
8-9:30 a.m.—West Jersey Hospital,
Voorhees
(*West Jersey Hospital*)

June

- 10 **Lessons Learned in an Intensive Care Unit**
8-9:30 a.m.—West Jersey Hospital,
Voorhees
(*West Jersey Hospital*)

CARDIOLOGY

May

- 13 **Cardiology Conferences**
27 3:30-5:30 p.m.—Middlesex General
Hospital, New Brunswick
(*CMDNJ, Somerset County Heart
Association and AMNJ*)

- 15 **Cardiac Rehabilitation**
12 noon—Freehold Area Hospital
(*AMNJ*)

- 16- **Advanced Echocardiography**
17 9 a.m.-5 p.m.—Nassau Inn, Princeton
(*National Foundation for Non-Invasive
Diagnostics and AMNJ*)

June

- 10 **Cardiology Conferences**
24 3:30-5:30 p.m.—Middlesex General
Hospital, New Brunswick
(*CMDNJ-Rutgers, Somerset County
Heart Assn. and AMNJ*)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

May

- 1 **Renal Conferences in Nephrology**
15 2-3:15 p.m.—College Hospital, Newark
(*Nephrology Society of NJ and AMNJ*)

- 5 **Peripheral Vascular Diseases**
11 a.m.—Greystone Park Psychiatric
Hospital
(*AMNJ*)

- 6 **Proper Use of Blood Gases**
11:30 a.m.—Rahway Hospital
(*AMNJ*)

- 6 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—VA Medical Center,

East Orange
(*AMNJ*)

- 6 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section, AMNJ*)

- 6 **Paget's Disease of the Bone**
20 **Hyperlipidemia**
9:30-11 a.m.—Bergen Pines County
Hospital, Paramus
(*Bergen Pines County Hospital and
AMNJ*)

- 6 **Dermatology in the Office Practice**
20 **Hormone Secreting Tumors of the
Digestive System**
9:30-11:30 a.m.—St. Clare's Hospital,
Denville
(*Dover General, Riverside and St. Clare's
Hospitals and AMNJ*)

- 6 **Recent Advances in Internal Medicine**
13 9-11 a.m.—Roosevelt Hospital, Menlo
20 Park
27 (*Middlesex General Hospital and AMNJ*)
6 **Medical Lecture Series**
13 1-2:30 p.m.—VA Medical Center, Lyons
20 (*VA Medical Center and AMNJ*)
27

- 6 **Medical Lecture Series**
13 1-3 p.m.—Christ Hospital, Jersey City
20 (*Christ Hospital and AMNJ*)
27

- 6 **Endocrine Conferences**
13 3:30-5 p.m.—Rotates between Newark
20 Beth Israel Medical Center, College
27 Hospital, Newark and VA Medical
Center, East Orange
(*Endocrinology Section, AMNJ*)

- 7 **Medical Grand Rounds**
9:30-11 a.m.—Newark Beth Israel
Medical Center
(*Endocrinology Section, AMNJ*)

- 7 **Immunology**
14 4-6 p.m.—Institute for Medical
21 Research, Copewood St., Camden
(*Institute for Medical Research and
AMNJ*)

- 8 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—College Hospital,
Newark
(*Endocrinology Section, AMNJ*)

- 9 **Adrenal Disease**
23 **Parenteral and Enteral Nutrition**
8-10 a.m.—Newcomb Hospital,
Vineland
(*Newcomb Hospital*)

- 12 **Metabolic Bone Disorders**
8-9 a.m.—Paterson General Hospital,
Wayne
(*Paterson General Hospital and AMNJ*)

- 13 **Narcolepsy**
9:30-11 a.m.—Bergen Pines County
Hospital, Paramus
(*Bergen Pines County Hospital and
AMNJ*)

- 13 **Pulmonary Embolism in Geriatric
Patients**
2 p.m.—John E. Rannels Hospital,
Berkeley Heights
(*AMNJ*)

- 13 **Viral Hepatitis—Update, 1981**
11 a.m.-12 noon—Ciba-Geigy, Summit
(*Ciba-Geigy Pharmaceuticals Division
and AMNJ*)

- 15 **New Approaches to Asthma**
7:45 a.m.—West Jersey Hospital,
Voorhees
(*West Jersey Hospital*)

- 15 **Hemodynamics of Human Hypertension**
26 **Catecholamine Metabolism in
Hypertension**
4:30-5:30 p.m.—St. Barnabas Medical
Center, Livingston
(*St. Barnabas Medical Center and
AMNJ*)

- 18 **The Critically Ill Patient**
12 noon-1 p.m.—Mountainside
Hospital, Montclair
(*Mountainside Hospital and AMNJ*)

- 19 **Fluid and Electrolyte Imbalance**
11 a.m.—Greystone Park Psychiatric
Hospital
(*AMNJ*)

- 19 **Hypercalcemia**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)

- 20 **Dermatological Conference**
6-8 p.m.—Rutgers Community Health
Plan, 57 U.S. Highway 1, New
Brunswick
(*CMDNJ*)

- 20 **Thyroid Function and Disease**
9-11 a.m.—West Jersey Hospital,
Voorhees
(*West Jersey Hospital*)

- 20 **Organic Acid Metabolism**
4-5 p.m.—Middlesex General Hospital,
New Brunswick
(*Nephrology Society of NJ and AMNJ*)

- 20 **Allergy in Adults**
1:30-2:30 p.m.—Rutgers Community
Health Plan—57 U.S. Highway 1, New
Brunswick
(*Rutgers Community Health Plan and
AMNJ*)

- 21 **Graduate Teaching Program**
5-6:30 p.m.—Somerset Medical Center,
Somerville
(*Somerset Medical Center and AMNJ*)

- 26 **Topic to be announced**
7:30-9 p.m.—Coachman Inn, Cranford
(*NJ Blood Club and AMNJ*)

- 26 **Cholesterol Gallstones**
12 noon-2 p.m.—West Jersey Hospital,
Camden
(*West Jersey Hospital*)

- 26 **Interferon, Immunotherapy**
8 p.m.—Warren Hospital, Phillipsburg

- (AMNJ)
- 27 **Diabetic Nephropathy**
1-2:30 p.m.—VA Medical Center, Lyons
(VA Medical Center and AMNJ)
- 29- **Advanced Trauma Life Support,**
30 **Provider's Course**
8 a.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

June

- 2 **Pulmonary Diseases**
- 16 **Rheumatology**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)
- 3 **The Treatment of Arthritis**
9:30-11:30 a.m.—St. Clare's Hospital, Denville
(Dover General, Riverside, and Saint Clare's Hospitals and AMNJ)
- 3 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—VA Medical Center, East Orange
(AMNJ Endocrinology Section)
- 3 **Endometrial Carcinoma**
11:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)
- 3 **Advances in Drug Therapy in GI Disease**
1-5 p.m.—Rutgers Medical School, Piscataway
(NJ Gastroenterological Society and AMNJ)
- 3 **Medical Lecture Series**
10 1-3 p.m.—Christ Hospital,
17 Jersey City
(Christ Hospital and AMNJ)
- 3 **Medical Lecture Series**
10 1-2:30 p.m.—VA Medical Center, Lyons
17 (VA Medical Center and AMNJ)
- 24

- 4 **Medical Grand Rounds**
9:30-11 a.m.—Newark Beth Israel Medical Center
(AMNJ)
- 5 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—College Hospital, Newark
(AMNJ)
- 5 **Renal Conferences in Nephrology**
19 2-3:15 p.m.—College Hospital, Newark
(Nephrology Society of NJ and AMNJ)
- 6 **Symposium on Asthma**
9 a.m.-4 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 9 **Skin in Systemic Disease**
12 noon-2 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)
- 13 **Topics in Gastroenterology**
All day—Golden Nugget, Atlantic City
(Underwood Memorial Hospital and Hospital of University of Pennsylvania)
- 16 **Treatment of Asthma**
12 noon—St. Mary's Hospital, Orange
(AMNJ)
- 17 **Common Disorders of the Esophagus and Stomach**
9-11 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)
- 17 **Acute Renal Failure**
11 a.m.—South Bergen Hospital, Hasbrouck Heights
(AMNJ)

- 17 **Dermatological Conference**
6-8 p.m.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick
(CMDNJ-Rutgers Medical School)
- 18 **Advanced Life Support Systems in Patients with Multiple Trauma**
5-6:30 p.m.—Somerset Medical Center, Somerville
(Somerset Medical Center and AMNJ)
- 19 **End State Renal Disorder**
12 noon—Freehold Area Hospital
(AMNJ)
- 19- **Symposium on Low Back Pain—**
20 **Non-Surgical Approach**
8-5 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)

NEUROLOGY/PSYCHIATRY

May

- 1 1-2:30 p.m.—Administrative Psychiatry
2:45-3:45 p.m.—Genetics and Psychiatry
4-5 p.m.—Medical Ethics
Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)
- 4 **A Secret in the Family**
8-10 p.m.—1046 So. Orange Ave., Short Hills
(Essex Psychiatric Doctors Seminar and AMNJ)
- 4 **Polymyositis**
- 11 **Case Presentation**
- 18 **Interictal Behavioral Disturbances in Patients with Complex Partial Seizures**
11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)
- 4 **Neuroscience Conferences**
11 11:30 a.m.-12:30 p.m.—Bergen Pines
18 County Hospital, Paramus
25 (Bergen Pines County Hospital and AMNJ)

- 5 **Psychiatric Case Conference**
12 7:30-9:30 a.m.—Trenton Psychiatric
19 Hospital
26 (Trenton Psychiatric Hospital and AMNJ)
- 6 **Geriatric Psychiatry**
1-3 p.m.—Ancora Psychiatric Hospital
(Ancora Psychiatric Hospital and AMNJ)
- 6 **Ongoing Child Psychiatry Case**
- 13 **Conference and Lecture**
20 8:30-10:30 a.m.—Trenton Psychiatric
27 Hospital
(Trenton Psychiatric Hospital and AMNJ)
- 6 **John B. Atkinson Memorial Lecture in Psychosomatic Medicine**
3-5 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)
- 7 **Neuropsychological Testing**
- 14 **Schizo-affective Illness**
- 21 **Outward Bound as an Adjunctive Therapy**
- 28 **Personality Disorders**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)
- 7 **Case Presentation**
- 14 **Rehabilitation and the Aged**
- 21 **Rehabilitation and the Aged**
- 28 **Rehabilitation and the Aged**
11 a.m.-12 noon—Greystone Park

Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)

- 13 **Topic to be announced**
6 p.m.—The Manor, West Orange
(AMNJ)
- 20 **Psychopharmacological Methods in Schizophrenia**
1:30-3 p.m.—Community Mental Health Center, NJ Medical School, Newark
(CMDNJ and AMNJ)

June

- 1 **Transference Psychosis**
8-10 p.m.—9 Marquette Rd., Upper Montclair
(Essex Psychiatric Doctors Seminars and AMNJ)
- 2 **Psychiatric Case Conference**
9 7:30-9:30 a.m.—Trenton
16 Psychiatric Hospital
23 (Trenton Psychiatric Hospital and AMNJ)
- 3 **Ongoing Child Psychiatry Case**
- 10 **Conference and Lecture**
17 8:30-10:30 a.m.—Trenton
24 Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)
- 4 **Case Presentation**
- 11 **Psychological Issues in Medicine**
18 11 a.m.-12 noon—Greystone Park
25 Psychiatric Hospital
(Greystone Park Psychiatric Hospital and AMNJ)
- 4 **Multiple Personality**
- 11 **Treating the Impaired Physician**
- 18 **Therapeutic Touch**
- 25 **Endorphins Update**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

OBSTETRICS/GYNECOLOGY

May

- 5 **Gynecological Oncology**
8-9 a.m.—Paterson General Hospital, Wayne
(Paterson General Hospital and AMNJ)
- 6 **Distinguished Lectures in Obstetrics and Gynecology**
6-7 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 28 **Value of Fetal Heart Rate Monitoring**
4-5:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

June

- 3 **The Abnormal Menstrual Period**
9-11 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)
- 25 **The Menstrual Cycle**
4-5:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

OPHTHALMOLOGY

May

- 12 **Eyes in Systemic Disease**
12 noon-2 p.m.—West Jersey Hospital, Camden
(West Jersey Hospital)

June

- 4 **Applications of Ultrasound in Ophthalmology**
7:30-9:30 p.m.—United Hospitals of Newark
(*NJ Institute of Ultrasound in Ophthalmology and AMNJ*)
- 17 **Congenital Glaucoma**
7-9 p.m.—United Hospitals of Newark
(*CMDNJ and AMNJ*)

PATHOLOGY

May

- 9 **Dermatopathology: A Practical Self-Assessment Course**
8 a.m.-4:30 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)

June

- 6 **Environmental Pathology**
9 a.m.-12 noon—Rutgers Medical School, Piscataway
(*NJ Society of Pathologists and AMNJ*)

PEDIATRICS

May

- 26 **Pediatrics Distinguished Lecturer Series**
8:30-10:30 a.m.—St. Joseph's Hospital and Medical Center, Paterson
(*St. Joseph's Hospital and AMNJ*)

June

- 15 **The Critically Ill Patient—Early Management**
12 noon-1 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)
- 19 **The Battered Child**
7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

RADIOLOGY

May

- 13 **Case Presentations**
7:45-10:15 p.m.—Morristown Memorial Hospital
(*Radiological Society of NJ and AMNJ*)
- 14 **Research and Development in Ultrasound**
7:30-9:30 p.m.—Overlook Hospital, Summit
(*NJ Institute of Ultrasound in Medicine and AMNJ*)

- 16 **Advanced Echocardiography**
9 a.m.-5 p.m.—Nassau Inn, Princeton
(*National Foundation for Non-Invasive Diagnostics and AMNJ*)

- 20 **Dinner Meeting**
6:30 p.m.—The Manor, West Orange
(*Radiotherapy Section, AMNJ*)

- 21 **Visiting Professorship Program**
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston

(*St. Barnabas Medical Center*)

- 21 **CT of the Kidney**
8 p.m.—The Hospital Center at Orange
(*Radiological Society of NJ and AMNJ*)

June

- 4 **Ultrasound in Ophthalmology**
7:30-9:30 p.m.—United Hospitals of Newark
(*NJ Institute of Ultrasound in Ophthalmology and AMNJ*)

- 11 **Cardiology**
7:30-9:30 p.m.—Overlook Hospital, Summit
(*NJ Institute of Ultrasound in Medicine and AMNJ*)

- 13- **Real-Time, Cross Sectional Sector Scanning**
9 a.m.-5 p.m.—Nassau Inn, Princeton
(*National Foundation for Non-Invasive Diagnostics and AMNJ*)

GENERAL SURGERY

May

- 5 **Tumor Conferences**
12 12 noon-1 p.m.—Morristown Memorial Hospital
19 Hospital
26 (*Morristown Memorial Hospital and AMNJ*)

- 11 **Surgical Grand Rounds**
4:30-5:30 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)

- 13 **Non-Invasive Techniques in Evaluation of Carotid Artery Occlusion**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)

- 14 **Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)

- 21 **Surgical Infections: Preoperative, Perioperative and Postoperative**
7:30-9 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

- 26 **Selective Surgical Procedures for Operative Breast Cancer**
8-9 a.m.—Paterson General Hospital, Wayne
(*Paterson General Hospital and AMNJ*)

June

- 2 **Primary Lesion of Melanoma**
5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)

- 2 **Tumor Conferences**
9 12 noon-1 p.m.—Morristown Memorial Hospital
16 Hospital
23 (*Morristown Memorial Hospital and AMNJ*)

- 11 **Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital,

Kearny
(*West Hudson Hospital and AMNJ*)

- 18 **An Approach to Breast Cancer**
7:30-9 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

- 23 **Surgery of Chronic Obesity**
8 p.m.—Warren Hospital, Phillipsburg
(*Warren Hospital and AMNJ*)

SURGICAL SPECIALTIES (includes ENT Neurosurgery, Orthopedic, Plastic, and Cardio-Vascular Surgery)

May

- 4 **Pediatric Open Heart Surgery**
4:30-5:30 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)

- 5 **Surgical Management of Bleeding Esophageal Varices**
5-6 p.m.—Rutgers Medical School, Piscataway
(*CMDNJ and AMNJ*)

- 6 **Sports Medicine**
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)

- 15 **Techniques of Thoracic Surgery**
8-10 p.m.—Baltusrol Country Club, Springfield
(*NJ Society of Thoracic Surgeons and AMNJ*)

- 19 **Myocutaneous Flaps**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)

- 21 **Clinical Management of Common Sports Injuries**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)

June

- 23 **Pars Plana Vitrectomy**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society and AMNJ*)

MISCELLANEOUS

May

- 6 **Basic Approaches to Financial Planning**
9-11 a.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

- 16- **MSNJ 215th Annual Meeting**
19 Meadowlands Hilton, Secaucus
(*Medical Society of New Jersey*)

- 27 **Annual Awards Dinner**
6 p.m.—Chanticleer, Millburn
(*AMNJ*)

June

- 23 **Health Insurance—What's It All About?**
12 noon-2 p.m.—West Jersey Hospital, Voorhees
(*West Jersey Hospital*)

OBITUARIES

Dr. Charles B. Battalino

Charles B. Battalino, D.O., a North Jersey general practitioner, died on January 19 at Riverside General Hospital in Secaucus. A native of New Jersey, born in 1912, Dr. Battalino was graduated from the Philadelphia College of Osteopathic Medicine in 1937, and pursued graduate studies in medicine and surgery there. In 1940 he established a practice in Camden and in 1947 moved to Hudson County where he practiced first in Union City and finally in North Bergen. Dr. Battalino had been on the staff at St. Mary Hospital in Hoboken and Riverside General Hospital in Secaucus. Active in civic affairs, he had served as police and fire surgeon in North Bergen and also as fire surgeon in West New York. Dr. Battalino had been a member of the housing authority, the welfare board, and board of education in North Bergen, and had served as school physician, first in Camden, and until his death, in North Bergen. Two of Dr. Battalino's children also are physicians. Dr. Barbara Battalino practices in North Bergen, and Dr. John Battalino is in New York City.

Dr. Marshall Bergen

The dean of Hudson County's orthopedic surgeons, Marshall Bergen, M.D., suffered a fatal heart attack while enroute to his office in Jersey City on January 17. Born in Poland, Dr. Bergen emigrated to the United States as a young child, and earned his medical degree at Long Island College of Medicine, class of 1930. He pursued a residency in orthopedic surgery at Jersey City Medical Center, was a Fellow of the American Academy of Orthopedic Surgeons and of the American College of Surgeons, and was a diplomate of the American Board of Orthopedic Surgery. Dr. Bergen served as director of the department of orthopedic surgery at Jersey City Medical Center and also had headed the orthopedic surgery departments at Christ Hospital and the Jewish Hospital and Rehabilitation Center in Jersey City. Last May he was a recipient of MSNJ's Golden Merit Award in recognition of his fifty years of service to

medicine. During World War II Dr. Bergen was in charge of orthopedics at the 53rd General Hospital in Worcester, England, with a rank of lieutenant colonel.

Dr. Alexander U. Bertland

On February 6, Alexander U. Bertland, M.D., a member of our Warren County component died in Warren Hospital, Phillipsburg, after a brief illness. A native of Yonkers, New York, Dr. Bertland spent his early life in Budapest (Hungary) and earned his medical degree at the school of medicine of the Royal Hungarian Peter Pazmany University of Budapest in 1938. After internships served both in Hungary and at the Bayonne Hospital in New Jersey, he completed a two-year residency in medicine at Morristown Memorial Hospital. Following two years of military service, Dr. Bertland began a general medical practice in Washington (NJ) and was active until immediately preceding his death. He had been affiliated with the Warren Hospital, all of his professional career and was a member of the staff at Hunterdon Medical Center in Flemington for some twenty-five years. Dr. Bertland was involved in medical affairs and had been president of his county medical society and long a member of JEMPAC. He was the husband of Margaret Bertland, president of the Medical Society of New Jersey Auxiliary in 1970-1971. Dr. Bertland was 74 years old at the time of his death.

Dr. Laurence M. Collins

Laurence M. Collins, M.D., a member of our Morris County component, died on January 18. A native of Bath, New York, Dr. Collins was graduated from Georgetown University Medical School in 1912 and established a practice in general surgery earning fellowship in the American College of Surgeons. In the early 1940s, Dr. Collins directed his career to the field of psychiatry and achieved certification by the American Board of Psychiatry and Neurology. He was Clinical Director of the New Jersey State Hospital at Greystone Park and had been affiliated also with All Souls

Hospital in Morristown and St. Clare's Hospital in Denville. During World War I, Dr. Collins served in the medical department of the AUS. In 1962 he received MSNJ's Golden Merit Award, marking his 50 years as a physician. Dr. Collins was 93 years old at the time of his death.

Dr. Claude B. Mackes

Word just has been received of the death on December 11, 1980 of Claude B. Mackes, M.D., a member of our Salem County component. A native of Pennsylvania, born in 1903, Dr. Mackes earned his medical degree at Temple University School of Medicine, class of 1929. He served his internship at Montgomery Hospital in Norristown, Pennsylvania, and a residency in Wilmington General Hospital (Delaware). In 1931 he established a practice in general medicine in Woodstown which he maintained until retirement in 1973. Dr. Mackes served one year as president of the Salem County Medical Society. In 1979 he was a recipient of MSNJ's Golden Merit Award, honoring his 50 years as a physician.

Dr. Raphael I. Soll

One of Bergen County's well-known ophthalmologists, Raphael Israel Soll, M.D., of Westwood, died on February 2. A native of New York City, born in 1934, Dr. Soll was graduated from the State University of New York, class of 1959, and served a residency in ophthalmology at the Brooklyn Eye and Ear Hospital. He had practiced briefly in Washington, D.C. before coming to New Jersey. At the time of his death Dr. Soll was chairman of the department of ophthalmology at the Pascack Valley Hospital in Westwood and was affiliated with the Valley Hospital in Ridgewood. He was certified by the American Board of Ophthalmology and was a Fellow of the American College of Surgeons and of the American Academy of Ophthalmology and Otolaryngology.

Dr. Adalbert Stein

We just have learned of the death of Adalbert Stein, M.D., on December 7

1980. Dr. Stein, a senior member of our Hudson County component, born in Germany in 1893, was graduated from the medical school of the University of Leipzig (Germany) in 1919. Upon emigrating to the United States, he established a practice in general medicine, with special interest in obstetrics and gynecology, in North Bergen. Dr. Stein was a Fellow of the American Society of Abdominal Surgeons. He had been affiliated with North Hudson Hospital in Weehawken. Dr. Stein was a recipient of MSNJ's Golden Merit Award in 1969, a tribute to his 50 years in the practice of medicine.

Dr. Francis I. Tomlins

The former chief of staff at Bergen Pines County Hospital, Francis I. Tomlins, M.D., died on February 5. A native of Brooklyn, Dr. Tomlins earned his medical degree from Temple Univer-

sity School of Medicine in 1935 and pursued a career in internal medicine and cardiology. In addition to Bergen Pines County Hospital, he had been affiliated with Valley Hospital in Ridgewood, Paterson General, St. Joseph's and Barnert Memorial Hospitals in Paterson. Dr. Tomlin had been a member of the Council on Public Relations of the Medical Society of New Jersey for six years and was active in community affairs, long having been school physician in Ridgewood and team physician for many high school sports. He was a member of the Ridgewood board of health and a founding director of the Bergen County Heart Association. Dr. Tomlin was a Fellow of the American College of Chest Physicians and of the American College of Sports Medicine, and a member of the American Geriatric Society, the American Heart Association, and the Association of Military Surgeons. Dr. Tomlin was 72 years old at the time of his death.

Dr. Chester I. Ulmer

Chester Isaac Ulmer, M.D., a member of our Gloucester County component, died on December 17, 1980. Born in Williamsport, Pennsylvania, Dr. Ulmer earned his medical degree at the Medico-Chirurgical College of Philadelphia, class of 1913, and in 1916 established a practice in general medicine in Gibbstown. He served Gibbstown for over forty years until his retirement in the early 1960s, and was honored by that community in 1975 by having a park in Gibbstown named for him in commemoration of his long service as a physician in that area. Dr. Ulmer was president of Gloucester County Medical Society in 1929, and served as secretary for five years (1945-1950). He had been affiliated with Underwood Hospital in Woodbury. Dr. Ulmer was a recipient of MSNJ's Golden Merit award in 1963, indicating fifty years as a physician. He was 92 years old at the time of his death.

BOOK REVIEWS

Current Medical Diagnosis and Treatment, 1981

Marcus A. Krupp, M.D., and Milton J. Chatton, M.D., Eds. Los Altos, California, Lange, 1981. Pp. 1100. (\$21).

When compendia of this type reach 20 editions, it is reasonable to conclude that they have been successful in meeting a need. This one, intended to serve as a desk reference for practicing physicians, deals in a straight-forward manner with the practicalities of dealing with a patient's complaints with respect to both diagnosis and management. It differs from current textbooks of medicine in minimizing the attention given to underlying patterns of physiological and biochemical mechanisms and in focusing on clinical manifestations.

Most of the sections I checked are indeed quite clear and concise and reasonably up-to-date. References are included with the most recent from 1978. Substantial reviews as well as original articles are cited.

Books of this type are essentially conservative in nature and cannot present the latest "advances," whether these be ephemeral or not. In that regard, this is unlikely to please specialists with respect to the discussion of their particular domains. Thus, one can question the suggestion that digitalis generally may be useful in pulmonary edema: it is not necessarily indicated in patients with myocardial infarction. A Swan-Ganz catheterization procedure to be the "most accurate and dependable method of assessing fluid balance" requires that the catheter be accurately placed. Problems of how to manage a patient with probable but not bacteriologically proven tuberculous meningitis are not addressed. There are other points of weakness.

But all in all, I found this to be a potentially useful desk book and I believe that it would be of considerable assistance not only to general internists but also to specialists dealing with problems not in their immediate domains.

Francis P. Chinard, M.D.

Inflammatory Bowel Disease, 2nd Ed.

Joseph B. Kirsner, M.D. and Roy G. Shorter, M.D. Philadelphia, Lea and Febiger, 1980. Pp. 693. Illustrated. (\$74).

The new edition of Kirsner's and Shorter's *Inflammatory Bowel Disease (IBD)*, published five years after the successful first edition, is a beautifully written and illustrated book that ranks among the "classics" in gastroenterology.

The American and European contributors are, as stated by the editors in their preface, those who have been in the vanguard of developing the new knowledge in IBD. The book has been arranged in seven different sections covering epidemiology, etiology, clinical features, pathology, endoscopy and radiology, therapy and prognosis. The clinical features, pathology, endoscopy and radiology sections are as complete as the practicing gastroenterologist or internist dealing with these patients would like to have. The quality of endoscopic photo-

graphs and radiographs is excellent and the descriptions that accompany them are concise and easy to follow. The index is well detailed and allows for a rapid finding of the topic desired to investigate.

This book serves as a prized addition to the library of any hospital library or practicing gastroenterologist. The price of \$74 is not too steep considering the quality of the publication and the enormous material covered. I have no hesitation in recommending this book to all librarians who want to have an up-to-date reference in IBD and to all physicians who deal with the problems created by this troublesome disease.

Geobel A. Marin, M.D.

Basic Biomechanics of the Skeletal System

Victor H. Frankel, M.D. and Margareta Nordin. Philadelphia, Lea and Febiger, 1980. Pp. 303. Illustrated. (\$20).

Dr. Frankel is professor of orthopaedics at the University of Washington. Ms. Nordin, a registered physical therapist, is an associate in the same department. Their book is an introduction of biomechanics for those who deal with musculoskeletal disorders. They have achieved their purpose admirably. They begin by describing the modern international system of units used to measure mechanical forces. Two sections follow. The first deals with biomechanics of the tissues of bone, cartilage and connective tissues. The chapter on cartilage was particularly interesting to this reviewer.

The second part deals with individual joints. The knee, hip, ankle, foot, shoulder and elbow are discussed in individual chapters. The last chapter deals with the lumbar spine. Each chapter is well summarized, and there are plenty of references for further study. Line drawings, graphs, and other illustrations are appropriate and clear. There is a helpful glossary of modern terminology. The necessary mathematical principles are clearly presented. The book is attractively bound and well produced.

Biomechanics has become increasingly important in the management of orthopedic disorders. Orthopedists, physiatrists, therapists and others interested in the physical aspects of practice will find this book to be very helpful. It should be useful also for those involved in training programs in these disciplines.

Daniel J. O'Regan, M.D.

Developments in Digestive Diseases

J. Edward Berk, M.D., Editor. Philadelphia, Lea and Febiger, 1980. Pp. 258. Illustrated. (\$24)

This book has 13 separate essays on important new aspects in gastroenterology including: endoscopic control of gastrointestinal bleeding, proximal gastric vagotomy, breath testing, enteral hyperalimentation, infectious diarrheas, immunology and genetic aspects of inflammatory bowel disease, functional scintigraphy, therapeutic use of biofeedback, new gut hormones, somatostatin, acute viral hepatitis—the latest on serology and therapeutics, and non-surgical biliary decompression.

The essayists are uniformly expert and their reviews thorough and evenhanded. The editing is good and there is no overlap or repetition. Any reader can learn something here, even an academic gastroenterologist who will be expert in only a few of the topics noted above. Some of the areas discussed are esoteric and of only theoretical interest but several are very practical and carefully detailed and would enable a reader to use the described tests properly or treat the discussed illnesses with greater understanding.

The chapter on biliary decompression gives the sources for the equipment used and could be employed to start doing the procedures described after a reasonable training period. The book is quite readable despite the variety of authors and would be a good source for authoritative update on any of the listed chapters without necessarily reading the entire book.

Norman Riegel, M.D.

Integrated Medicine, Vol. II of A Companion to the Life Sciences.

Stacey B. Day, M.D., Ed. New York, Van Nostrand Reinhold, 1981. Pp. 625. Illustrated. (\$32.50).

I found this collection a pleasant surprise. There are some sixty or so essays arranged in four groups which encompass not only basic approaches but also pragmatic clinical and technological advances. Thus, we are offered a concise review by a biophysicist of the possible role of lipids in cell membranes and body fluids and of the concept that changes of lipid fluidity may not only be determinants of cell membrane charac-

teristics but also indicators of abnormalities of cell growth. A bit further on there is a discussion of the feasibility of an artificial endocrine pancreas. Deep-sea diving and medical problems at high altitudes are among the physiological topics. One group of essays covers diseases of blood vessels including coronary artery bypass and brain revascularization, the last group of which has a sharply technological focus on topics such as microsurgery, breast reconstruction and organ transplantation. The social aspects of medicine are not ignored, with several contributions by the editor of this volume and one from Cuernavaca, Mexico by Valentina Borremans on "use-value oriented convivial tools" with an introductory note by Ivan Illich.

Clearly, this is a hodge-podge. Many of the articles are speculative; most are descriptive rather than quantitative; all are written by recognized authorities in the fields of concern. The articles I sampled were well organized, concise and to the point and reasonably up-to-date. The bibliographies are brief, in some instances non-existent. The illustrations are few but relevant. The essays are generally easier to read than most in the *Scientific American*.

This collection could be of interest to medical students seeking indications of where certain fields are headed, of little use to residents seeking board certification, of substantial benefit to those academicians and practicing physicians who seek an insight into the more or less current status of progress in other fields than their own.

Francis P. Chinard, M.D.

A Method of Psychiatry

Editorial Board: Dept. of Psychiatry, University of Toronto, Canada. Philadelphia, Lea and Febiger, 1980. Pp. 375. Illustrated. (\$20)

Independence of thought in medical matters is a prized characteristic of the practicing physician. Although at times he may seek consultation, in the last analysis the final decision rests with the "attending." Medical school faculty apparently are no less independent minded. More and more, in recent years, groups of teachers from within a single academic department, unhappy with existing textbooks, have developed their own. These usually are based on the material which they present in their lectures to medical students. A few of these

books clearly are of high quality, being both broad in scope and of sufficient depth properly to orient the student reader to the subject matter. However, others suffer from being either too narrow or too superficial.

A new text in psychiatry titled *A Method of Psychiatry*, which has an editorial board and a list of contributors all drawn from the Department of Psychiatry of the University of Toronto, in most part falls into the latter category.

The book begins with an overview of the field and then proceeds to describe the stages of human personality development. There follows a review of the characteristics of the major psychiatric disorders and of their treatment. One strong point of the book is that the authors devote a number of chapters to a discussion of the doctor/patient relationship and to the role of the non-psychiatric physician in the diagnosis, the treatment, and in the referral of psychiatric patients.

The organization of the material is effective and clearly is designed to make the integration of information simpler for the student reader. Furthermore, throughout the book, the authors strive to view the patient from a respectful perspective.

However good the intent, this volume suffers badly from lack of depth. On the average, a chapter devoted to the discussion of a major psychiatric disorder consists of no more than six or seven pages. Their attempt to cover most of the field in such a spare manner barely allows for an overview of each topic. There is insufficient information to permit either student or graduate physician

to use this book as a major resource for understanding modern psychiatric practice. Because it is brief and easy to digest, the text might serve a student reader as a handbook, but for the practicing physician there is little to recommend it.

Irwin W. Pollack, M.D.

Theories on Drug Abuse: Selected Contemporary Perspectives

National Institute of Drug Abuse. Washington, DC, U.S. Printing Office, 1980. Pp. 488. (No price given)

This monograph, edited by Dan J. Lettieri, Mollie Sayers and Helen Wallenstein Pearson, provides chapters on forty-three theoretical perspectives representing the work of more than fifty theorists. Each contributor aims to explain all or part of the problems of drug abuse, and in the first part of this book is given relatively free reign to present an overview of his position. The chapters are classified into four broad categories: "Theories on One's Relationship to Self," "to Others," "to Society," and "to Nature." The authors include leading experts on alcoholism and drug dependence from Europe as well as the United States.

The second part of the volume is highly structured and shows how each of the authors explains (1) why people begin taking drugs, (2) why they continue, (3) how or why drug-taking escalates to drug abuse, (4) why or how people stop taking drugs, (5) what accounts for re-

lapse. Several guides to the organization of the book make it useful to the casual reader.

NIDA makes single copies of its Research Monograph series available without charge from the National Clearinghouse for Drug Abuse Information.

Physicians interested in problems of drug abuse will find much of importance here. Ask your hospital librarian to send for a copy from NCDIA, Room 10A-56, 5600 Fishers Lane, Rockville, Md. 20857.

A. Arthur Sugarman, M.D.

New Jersey Programs and Services Related to Adolescent Pregnancy: Resource Book

Pediatricians, obstetricians and family physicians may be interested in a *Resource Book: New Jersey Programs and Services Related to Adolescent Pregnancy*, compiled by Rutgers University. As the title indicates, the book lists county networks on adolescent pregnancy, public and voluntary agencies and individuals associated with the Network and many others.

A copy is available for perusal in the Medical Affairs office at MSNJ headquarters in Lawrenceville. Copies are available from the Department of Community Education, Rutgers University, 35 College Avenue, New Brunswick 08903. Only prepaid orders are accepted—\$15 (\$12 for subscribers to *Exchanges*, the newsletter issued by the New Jersey Network on Adolescent Pregnancy).

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$16,100 to \$18,400 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

THE MORE YOU KNOW ABOUT CHOICES, THE EASIER IT IS TO CHOOSE. That's why CompHealth, the oldest, largest locum tenens organization in the United States, can help make choices easier for you. Any specialty can be covered including: F.P., I.M., Rad., Anes., and OB/GYN. With a large selection of reliable, qualified physicians to choose from, CompHealth provides physicians, hospitals, clinics and communities with dependable locum tenens coverage, allowing you to keep your practice covered without inconvenience or concern. Turn a difficult decision into an easy choice. Contact **COMPHEALTH**, 175 West 200 South, Suite 2003, Salt Lake City, UT 84101 (801) 532-1200.

NEEMA EMERGENCY MEDICAL —a professional association—

Emergency Medicine Positions—available with emergency physician group in Pa., N.Y., N.J., Va., W. Va., Md. and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical	
Suite 400	or phone
399 Market Street	in Pa., (215) 925-3511
Philadelphia, Pa. 19106	outside Pa., 800-523-0776

PHYSICIANS

All specialties. Regularly scheduled hours, respectable salary, malpractice paid, free health/dental, 30 days paid vacation, many family benefits and more. Must qualify for commissioned officer in Navy Medical Corps.

Send C. V. to
Medical Programs Officer
128 N. Broad St.
Philadelphia, PA 19102
or call
(215) 597-9680
or 564-3820.

CLASSIFIED ADVERTISEMENTS

GENERAL INTERNIST—Available July 1981. Seeking position as full time or preferably practice as solo, associate or in a group involving direct patient care. Please respond to L. Rohra, (212) 458-9609.

GENERAL SURGERY RESIDENT—Seeking General Surgery group or partnership practice, available July 1981. Board eligible. John L. Driscoll, M.D., 631 Avenue E, Bayonne, NJ 07002.

OB/GYN—Board eligible, seeking group or partnership opportunity. Available immediately. Write Box No. 238, c/o JOURNAL MSNJ.

PEDIATRICIAN—Board certified. Seeks part-time pediatric work in any setting one weekday and/or weekend in South Jersey. Write Box No. 232, c/o JOURNAL MSNJ.

THERAPEUTIC RADIOLOGIST—Well trained in major university hospital. Seeks independent or associate position. Board eligible. Husband, experienced physicist will also join. Available '81. Call (212) 430-3246, Dr. Krish.

PEDIATRIC ASSOCIATE—New Jersey Shore area, 1½ hours to New York City and Philadelphia. Write Box No. 235, c/o JOURNAL MSNJ.

ASSOCIATE WANTED—Family Practice Associate. Just 25 miles west of the Big Apple. Work part of the time, study or have fun the rest of the time. Make full income. Friendly town of considerate people (13,000). A 350-bed hospital 5 minutes away. Write Box No. 230, c/o JOURNAL MSNJ.

PHYSICIAN—Downtown Newark Industrial Clinic. Monday through Friday, 9 to 5. Good salary, excellent benefits. Call (201) 643-4969.

NEEDED—GENERAL PRACTICE to buy. Elizabeth. Call (201) 289-4227 or (212) 698-5541.

NEEDED—Used x-ray equipment. 300-500 milliamperes, in good condition with or without fluoroscopy. Call (201) 240-4031 after 5:00 p.m.

FOR SALE—EK 4. EKG machine with stand. Call between 3:00-5:00. (201) 947-6545.

INFORMATION FOR MEMBERS—RATES—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT**: Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JOURNAL MSNJ" as six words. **COPY DEADLINE**: Fifth of preceding month.

PEDIATRIC PRACTICE—FOR SALE—Practice has been established in Newark for 6 years. Have more than ten thousand charts. Good for pediatricians also board certified family physicians. Sale price \$5,000.00 including equipment. Write Box No. 238, c/o JOURNAL MSNJ.

PRACTICE/HOME/OFFICE—FOR SALE—Long established G.P. practice, office furnishings and spacious office-residence for sale due to recent death of my husband. Outstanding Colonial-Revival structure, circa 1906, centrally located in professional-residential zone of small town (pop. 8,000) in a rural but developing area of Warren County in northwest New Jersey. Two hospitals nearby. Excellent location and opportunity for young family practitioner or internist. Write Box No. 48, Washington, NJ 07882 or call (201) 689-1705.

FOR SALE—Active CP and Contract Allergy Practice. Five bedroom colonial home plus completely equipped A/C office in a prime residential area in New Jersey, preferably to a qualified CP or Internist with interest in allergy. Write Box No. 237, c/o JOURNAL MSNJ.

FOR SALE—Family Practice with building. Will consider taking on associate with idea of eventual purchase. Immediate availability. Camden/Pennsauken area. Send reply to P.O. Box 3032, Cherry Hill, NJ 08034.

FOR SALE—Office Building and Home. Cherry Hill. Well established Family Practice-office sharing-hospital affiliation. Take back mortgage. Call (609) 665-4666 or 667-3015.

FOR SALE—Office and Home of deceased physician. Excellent location, Upper Irvington, on all bus routes, near schools and hospitals. Layout suitable for single or group practice also rental income. Parking on premises. Call 7-11 a.m. or 8-11 p.m., 201-373-6165.

FOR SALE—Office and Home—10 room physicians office and home in prime year-round seashore location. Established over 30 years. Community need. Hospitals near-by. Inground pool, rental cottage, garden area. (201) 899-0920.

WISHES TO SHARE—Young physician wishes to share existing available office space in the West Essex or Morris County areas, or locating another physician who wishes to share expenses for a new office. Please contact Box No. 236, c/o JOURNAL MSNJ.

OFFICE SPACE—For Rent, medical office space, new and fully equipped, part/full time. Ocean Medical Park, Bricktown, NJ 08723. Call (201) 295-9003.

OFFICE SPACE—Edison. New modern professional building. Will divide. Need all specialties. On site parking, near all major highways. Call Dr. M. Bronstein (201) 826-5606.

OFFICE AVAILABLE—Elizabeth. Private medical office available immediately. 1150 square feet fully equipped and beautifully furnished and carpeted. X-ray machine, central air conditioning, parking lot, excellent location. Call (201) 643-4444 weekdays 9 to 5.

OFFICE SPACE—Professional office suite For Sale or Lease. Hazlet Medical Building. Five minutes from Bayshore Community Hospital. Call (201) 747-2262 or 739-3420.

OFFICE SPACE—For Rent in medical office in Kenilworth. Call (201) 272-5750.

OFFICE SPACE—1,300 square feet, can be divided. Growing suburban area, universities, office parks, three teaching hospitals. Ten other health professionals, including x-ray and lab in building. Madison Medical Center, 28 Walnut Street, Madison, NJ 07940.

OFFICE SPACE—Parsippany. Ideal satellite office, 400 square feet. Professional building. Purchase as a condominium or rent. Excellent location in Parsippany. Call (201) 887-7444.

OFFICE SPACE—Choice space opposite South Amboy Hospital. Approximately 1,000 square feet. Close to Perth Amboy hospital (3 miles). (201) 727-1211.

LITERATURE SEARCHES—NJMS student with graduate degrees in basic and in behavioral science desires to do literature searches in summer 1981. Write Box No. 231, c/o JOURNAL MSNJ.

IRISH WOLFHOUND PUPPIES—For sale. Home bred, ready April 1, 1981. Crave human companionship. W.F. Judge, M.D., Spring Lake, NJ. Evenings (201) 449-3282.

**DISABILITY INCOME-PROFESSIONAL
OVERHEAD EXPENSE**

Issued at ages 61-67
up to \$5000.00 per month—Professional Over-
head Expense
up to \$1000.00 per month—Disability Income
Issued subject to usual medical & participation
limits

Please call—reverse charges

Robert E. Segal, CLU
Field Representative
Monarch Life Ins. Co.,
P.O. Box 324
Mt. Freedom, N.J. 07970
Telephone (201) 992-5137

MOVING YOUR OFFICE

If you're planning on moving your office in or out of the North Jersey area, HEMMINGS MOVING & STORAGE CO. can be of service. We've been offering prompt, efficient, courteous service since 1924. Hourly and weight rates available. We can also coordinate the move of your residence along with your practice.

For more information, call or write:

John Hemmings
Hemmings Moving & Storage Co.
P.O. Box 596, Rt. 24W
Chester, NJ 07930
201-876-4226
201-526-6463



Mayflower

Certified Investment Gems



(WHOLESALE)



DIAMONDS

SAPPHIRES

RUBIES

EMERALDS

(215) 364-3552

The Diamond Group Ltd.

SUITE 101, 1111 STREET ROAD
SOUTHAMPTON, PA 18966

REDWOOD DECKS

Call Mike

The Fancy Deck Builder

(201) 595-6263

**IDEAL FOR PROFESSIONAL
OFFICE/HOME**

**84 Eagle Rock Avenue, Roseland NJ
Essex County**

Three year old all brick Colonial with totally maintenance-free exterior, situated on one + acres. Four bedrooms, 2 1/2 baths. Center hall and all baths are imported Italian tile. Living room, dining room, kitchen, laundry room and two offices, powder room and family room with cathedral ceiling and parquet floors. Spacious kitchen cabinets, microwave oven and much, much more. Full above grade basement readily convertible to office use. Four-car garage, ample parking. Gas/hot water heat, central air. Many other special features. Offered at \$214,500.00 Call owner to inspect.

Christian N. Peter (201) 887-5100 9am-5pm (201) 226-3809 after 6 pm

OFFICE SPACE FOR RENT

Office space available next to a Dental Office in a new professional building located on Main Street, Manville, New Jersey. Somerset Medical Center is five minutes away. Presently, one semi retired general practitioner in town of 14,000 plus. Presents an unusual opportunity for an immediately successful practice.

Call (201) 722-2928 for additional information.

**PROFESSIONAL OFFICE
SPACE FOR RENT**

- PEOPLES PLAZA PROFESSIONAL BUILDING located on Route 206 in Growing Sussex County
- Presently no physicians practicing in Byram Township. Great demand for medical services exist
- Occupancy in new elevated building located in Shopping Mall (PEOPLES PLAZA) with parking for over 500 cars
- Occupancy in October 1981

CALL 992-1275

May 1981

Journal of
the Medical
Society of

New Jersey

Lumbar Spinal Stenosis
O. R. Hubschmann, M.D.
F. J. Weisbrot, M.D.

Use of Antidepressants
C. Goldfarb, M.D.
G. Keating, M.D.

Calcium Pyrophosphate
Deposition Disease
E. G. Moss, M.D.
S. D. Solomon, M.D.

Ezra Mundy Hunt—
Physician, Writer,
Humanitarian
Sam Alewitz

*Complete Table of
Contents on page 336*

LIBRARY
U.C. SAN FRANCISCO

MAY 27 1981

The Library
Acquisitions Division
Univ. of Calif., San Francisco
San Francisco, Calif. 94143

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

***Check this list
against your
coverages***

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$7,500 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

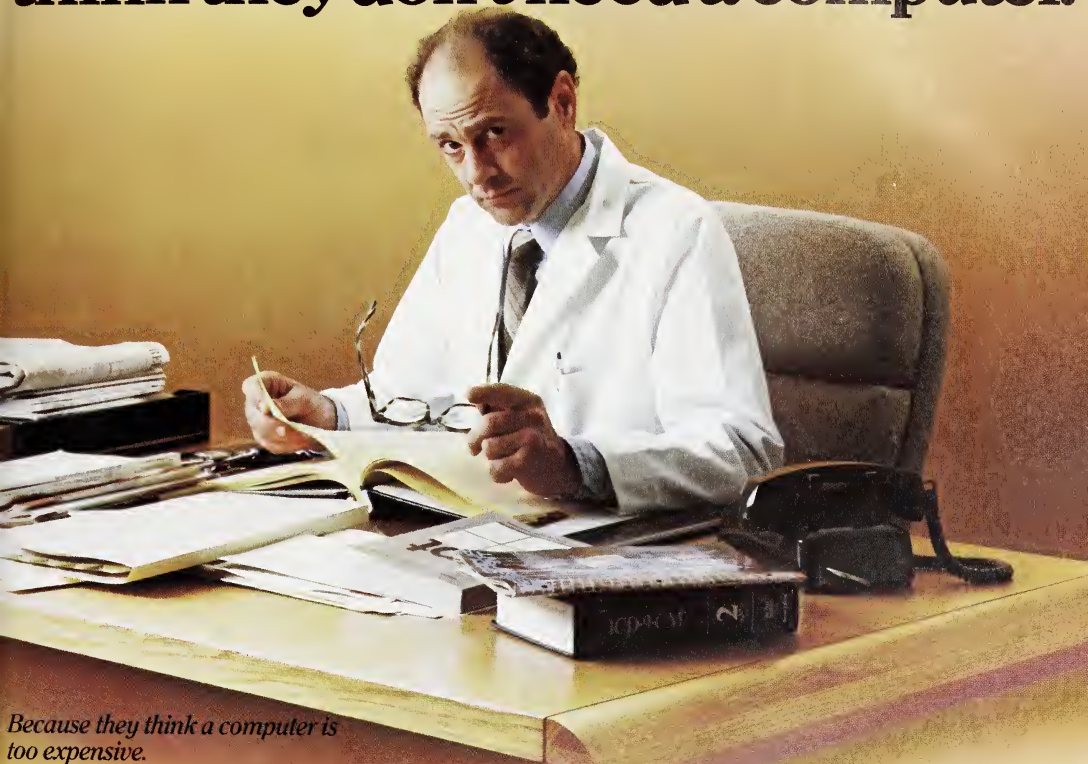
Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____

We're looking for doctors who think they don't need a computer.



Because they think a computer is too expensive.

The Sequoia Medical System™ can pay for itself:

- Increased collections
- Decreased receivables
- Improved staff efficiency

Because they think they already have firm control of their billing.

The Sequoia Medical System automatically processes billing paperwork:

- Patient statements
- Third party claims
- Collection letters

Because they think they have easy access to vital practice data.

The Sequoia Medical System provides information immediately:

- Aged receivable reports
- Procedure and diagnosis analysis

- Daily production and revenue analysis
- On-line access to 4½ million medical journal articles in the National Library of Medicine
- And many other forms of essential data

Because they think a computer is administratively disruptive.

The Sequoia Medical System is designed to blend smoothly into solo and small group practices:

- Easy to use
- Pre-programmed, turn-key system

- Includes training, installation, local service and support.

Because they haven't seen a Sequoia Medical System.

Sequoia can provide more time for health care in your practice. While it's taking care of business... you're taking care of patients.

Start looking into the benefits of a computer today by calling Sequoia Group. Call toll free (800) 227-2360; in California (800) 772-2655... or write for our brochure.

SEQUOIA GROUP™

I N C O R P O R A T E D

1100 Larkspur Landing Circle, Larkspur, CA 94939

Hackettstown (201) 852-1612 or 852-5394

Michael Keys—Branch Manager

Atlanta, Birmingham, Boston, Buffalo, Charlotte, Chicago, Cleveland, Columbus, Dallas, Denver, Detroit, Hartford, Houston, Indianapolis, Irvine, Kansas City, Los Angeles, Memphis, Miami, Minneapolis, Nashville, New Orleans, New York City, Norfolk, Oklahoma City, Philadelphia, Phoenix, Pittsburgh, Portland, Salt Lake City, San Diego, San Francisco, Seattle, St. Louis, Tampa, Washington, D.C.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



Officers and Trustees

PRESIDENT

Augustus L. Baker, Jr., M.D. (Morris) Dover

PRESIDENT-ELECT

Armando F. Goracci, M.D. (Gloucester) Woodbury

FIRST VICE-PRESIDENT

Howard D. Slobodien, M.D. (Middlesex) Perth Amboy

SECOND VICE-PRESIDENT

Alexander D. Kovacs, M.D. (Union) Scotch Plains

IMMEDIATE PAST-PRESIDENT

Alfred A. Alessi, M.D. (Bergen) Hackensack

SECRETARY

Arthur Bernstein, M.D. (Essex) East Orange

TREASURER

Rudolph C. Gering, M.D. (Mercer) Pennington

Trustees

CHAIRMAN

William Greifinger, M.D. (1981) (Essex) Belleville
Meyer L. Abrams, M.D. (1982) (Burlington) Cherry Hill
Frank Campo, M.D. (1981) (Mercer) Trenton
Douglas M. Costabile, M.D. (1981) (Union) Murray Hill
John J. Crosby, Jr., M.D. (1981) (Hudson) Jersey City
Anthony P. DeSpirito, M.D. (1982) (Monmouth) Neptune City
Ralph J. Fioretti, M.D. (1983) (Bergen) Rochelle Park
Palma E. Formica, M.D. (1981) (Middlesex) Old Bridge
Sherman Garrison, M.D. (1983) (Cumberland) Bridgeton
John P. Kengeter, M.D. (1981) (Ocean) Toms River
Richard E. Lang, M.D. (1981) (Passaic) Passaic
Myles C. Morrison, Jr., M.D. (1982) (Morris) Morristown
John A. Surmonte, M.D. (1981) (Salem) Penns Grove
Frank Y. Watson, M.D. (1983) (Essex) Montclair

Councilors

FIRST DISTRICT

(Essex, Morris, Union, and Warren Counties)

Merton L. Griswold, Jr., M.D. (1981) Plainfield

SECOND DISTRICT

(Bergen, Hudson, Passaic, and Sussex Counties)

Robert A. Weinstein, M.D. (1983) Newton

THIRD DISTRICT

(Hunterdon, Mercer, Middlesex, and Somerset Counties)

Albert F. Moriconi, M.D. (1982) Trenton

FOURTH DISTRICT

(Burlington, Camden, Monmouth, and Ocean Counties)

Frederick W. Durham, M.D. (1981) Haddonfield

FIFTH DISTRICT

(Atlantic, Cape May, Cumberland, Gloucester, and

Salem Counties)

Ronald M. Fisher, M.D. (1983) Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982) Hackensack
William J. D'Elia, M.D. (1981) Spring Lake
Frederick W. Durham (1982) Haddonfield
Karl T. Franzoni, M.D. (1982) Trenton
John S. Madara, M.D. (1982) Salem
Henry J. Mineur, M.D. (1982) Cranford

May 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*

Julio C. del Castillo, M.D.

John F. Marshall, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

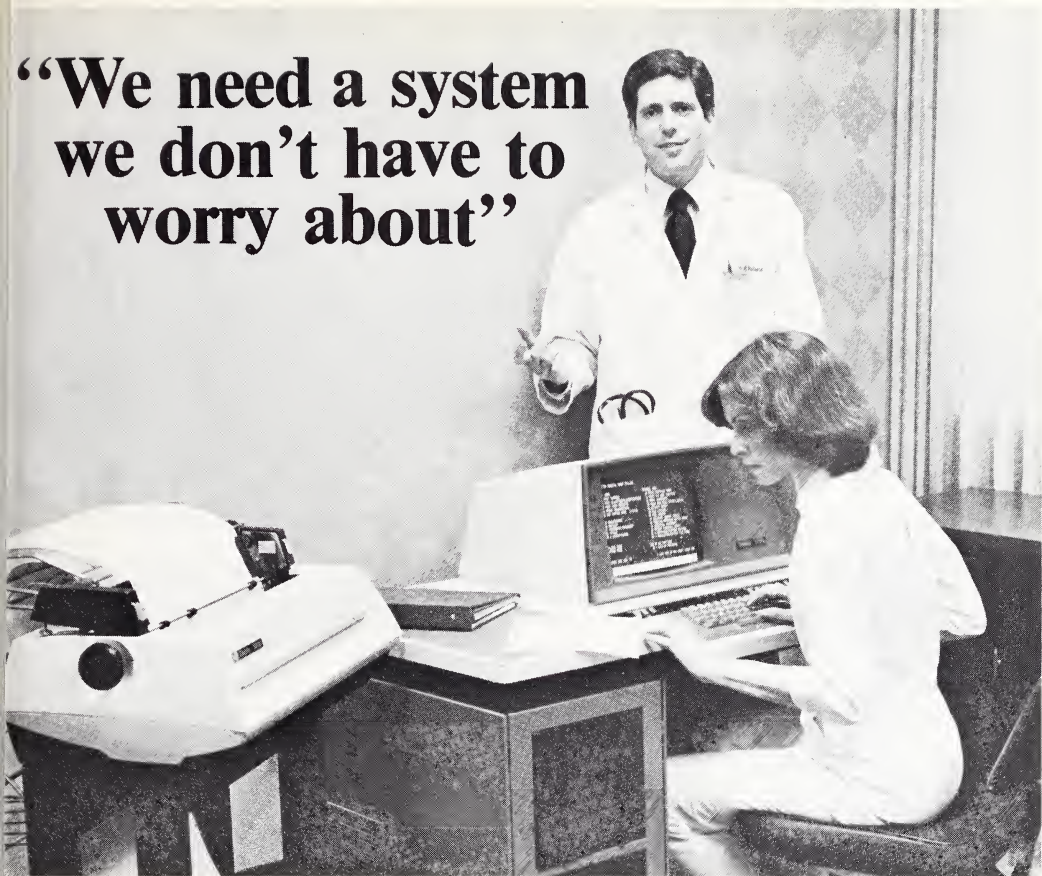
Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.
Harold Arlen, M.D.
Alfonse Cinotti, M.D.
Stuart D. Cook, M.D.
Robert Dodelson, M.D.
Wm. A. Dwyer, Jr., M.D.
Norman H. Ertel, M.D.
A. Olusegun Fayemi, M.D.
Arthur Goldfarb, M.D.
Robert A. Goldstone, M.D.
Murray Kahn, M.D.
Monroe S. Karetzky, M.D.
Avrum L. Katcher, M.D.
Sidney Ketyer, M.D.
Bernard J. Koven, M.D.
Joel D. Levinson, M.D.
Henry R. Liss, M.D.
Robert M. MacMillan, M.D.
Geobel A. Marin, M.D.
Murray Nussbaum, M.D.
Christopher M. Papa, M.D.
Victor Parsonnet, M.D.
Irwin Pollack, M.D.
Bernard A. Rineberg, M.D.
Edwin L. Rothfeld, M.D.
Benjamin F. Rush, Jr., M.D.
Morris H. Saffron, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Sheldon D. Solomon, M.D.
Lloyd N. Spindell, M.D.
A. Arthur Sugerman, M.D.
Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 924. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

"We need a system we don't have to worry about"



Dr. I. David Weisband, of the Regional Orthopedic Professional Association, is one of a growing number of physicians who've found Minicom's Medical Practice Management System meets the unique needs of a medical practice.

Automatic preparation of statements, Medicare and insurance company forms; instantaneous, up-to-the-minute accounts receivable information, plus a variety of practice analysis reports.

"We treat patients, not computers," Dr. Weisband says, "so we need a system we don't have to worry about."

And our Medical Practice Management System is just that. It

features reliable Xerox Diablo equipment and is backed by our policy of Unsurpassed Service—hardware, software, training, maintenance and system back-up, all from one reliable source.

"Our office manager and accounting firm investigated alternatives," he continues, "and recommended the Minicom system as the best solution to our needs. I agree."

So, before you invest in a computer system for your practice, take his advice. Look into our Medical Practice Management System. Drop the coupon in the mail, or give us a call...and ask about US!

I'd like more information on Minicom's Medical Practice Management System.

Name

Address

City, State, Zip

Telephone (Area Code)



MINICOM

1415 E. Marlton Pike,
Cherry Hill, N.J. 08034
(609) 429-0600
(215) 925-6908

UNSURPASSED SERVICE

Distributors of Xerox business and professional computer systems.

Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

340 PROFESSIONAL LIABILITY COMMENTARY

EDITORIALS

- 343 The Editor's Desk
343 Coffee and Cancer

346 RETIRED LIVES RESERVE

347 JEMPAC REPORTORIAL

ORIGINAL ARTICLES

- 351 The Syndrome of Lumbar Spinal Stenosis and Its Surgical Treatment
Otakar R. Hubschmann, M.D.; Frederick J. Weisbrot, M.D., Newark
357 Use of Antidepressants from Conception to Delivery
Charles Goldfarb, M.D., Staten Island; Garrett Keating, M.D., Plainfield
362 Delayed Hypersensitivity to Thimerosal in Contact Lens Solutions
Scott R. Zeigen, B.A.; I. H. Jacobs, M.D.; G. I. Weinberger, M.D., Newark
369 Calcium Pyrophosphate Deposition Disease
Edward G. Moss, M.D.; Sheldon D. Solomon, M.D., Camden

CASE REPORTS

- 374 Pseudo-Bladder Neck Syndrome in Women: Value of Gray-Scale Ultrasonography
L. Gould, M.D., Lyons; R. Patel, M.D.; R. Burbella, M.D., Newark
377 Pyogenic Liver Abscess Secondary to Toothpick Penetrating Gastrointestinal Tract
F. Ratizadeh, M.D.; H. Silver, M.D.; S. Fieber, M.D., Livingston
379 Nephrocutaneous Fistula
A. S. Karfopoulos, M.D.; W. Murray, M.D.; F. J. Stone, M.D., Perth Amboy

MEDICAL HISTORY

- 381 Ezra Mundy Hunt—Physician, Writer, Humanitarian
Sam Alewitz, Clementon

389 THERAPEUTIC DRUG INFORMATION

391 PEDIATRIC BRIEFS

DOCTORS' NOTEBOOK

- 394 Trustees' Minutes: March 15, 1981
396 Report from the Foundation
397 CMDNJ Notes
397 Physicians Seeking Location in New Jersey

401 LETTERS TO THE JOURNAL

402 LETTERS FOR THE INFORMATION OF OUR READERS

405 CME CALENDAR

407 OBITUARIES

408 BOOK REVIEWS

Cover

The photograph of our editor's desk (see editorial, page 343, this issue) was taken by Ernestine Ruben, a Princeton photographer. Her work has been published in *The New York Times* and she has had numerous exhibits in New York City.



NJR Welcomes Orthotic and Prosthetic Consultations

Consultation with an Orthotic and Prosthetic expert before an amputation is making speedier rehabilitation possible, since it allows the surgeon to plan his operation to conform best with the replacement device.

Unfortunately, there are very few certified Orthotists and Prosthetists. Simon Chang, chief of NJR's Orthotic and Prosthetic lab, is among the experts who regularly provide such pre-operative information. He is also one of less than two dozen people in the country who can make certain extremely complicated devices.

For information on NJR's Orthotic and Prosthetic Consultation Service, please phone Bertrand J. Bensam, MD, at (201) 673-1860. Rehabilitation is a total team effort.



New Jersey Rehabilitation Hospital

Owned and operated by Moderncore Centers of America, Inc.

240 Central Avenue, East Orange, NJ 07018 • 201-673-1860

Bertrand J. Bensam, MD, Medical Director • Anthony G. DiCarlo, Administrator

Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities and the American Board for Certification in Orthotics and Prosthetics Inc.

Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white glossy

prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.

for "cardiac separation"...



Although over 80% of post-coronary patients can resume normal marital sexual activity, fear of anginal pain often results in "cardiac separation" between patients and their families.

You can help minimize "cardiac separation" with a program of

counseling and often, with a prescription for Cardilate® (erythrityl tetranitrate).

Cardilate® increases exercise tolerance, helps patients return to more normal levels of activity—including sexual activity.

Sublingually, Cardilate begins to

work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to 2 hours.

counsel &
Cardilate®
(erythrityl tetranitrate)

CARDILATE® (ERYTHRITYL TETRANITRATE)

INDICATIONS: Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

CONTRAINDICATIONS: Idiosyncrasy to this drug.

WARNING: Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Intraocular pressure is increased, therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross tolerance to other nitrites and nitrates, may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspira-

tion and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION

Oral/Sublingual Tablets: Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg, prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED

CARDILATE (Erythrityl Tetranitrate) TABLETS (Scored):
for ORAL or SUBLINGUAL USE: 5 mg. Bottle of 100
10 mg. Bottles of 100 and 1000. 15 mg. Bottle of 100.

Reference: 1. Hellerstein HK, Friedman EH. Sexual activity and the postcoronary patient. Arch Intern Med 125:987-1970.

Burroughs Wellcome Co.,
Research Triangle Park, North Carolina 27709



Featuring: Southern California Physicians' Refund from Travelers

SOUTHERN CALIFORNIA PHYSICIANS RECEIVE \$18.6 MILLION REFUND FROM TRAVELERS

After three years of negotiations, the Southern California Physicians Council, Inc. (SOCAP) has reached an agreement with Travelers Insurance Co. which will return as much as \$46 million in malpractice premiums to some 5,500 physicians.

An administrative plan is now being formulated by SOCAP to return the initial payment of \$18.6 million, but it is estimated that it may take as long as six months before the first checks are mailed.

Malpractice Lifeline, in its February 28, 1981 issue, offers the following succinct summary of events which led to this rebate arrangement:

"At issue was a provision in the original five-year Travelers' contract with SOCAP that called for return of any company profits in excess of five percent to insureds. The past history of the SOCAP agreement with Travelers must be briefly explained to put the controversy into focus. Malpractice premiums for Southern California doctors began to rise significantly back in 1968 when Pacific Indemnity, which insured a high percentage of MDs in the area, hiked rates by 110 percent; a similar increase followed in 1969. That prompted formation of the Southern California Physicians Council in 1970, an organization of seven county medical societies in the Los Angeles area. SOCAP then sponsored a professional liability program underwritten by Hartford Insurance Company which brought an immediate premium decrease of 22 percent and for the next three years or so, rate increases were held to below nine percent.

"In the early 1970s it now appears that Hartford lost millions on the SOCAP coverage, as claims escalated and awards and settlements multiplied. Hartford attempted to rectify the deteriorating situation by putting a 100 percent rate increase in 1974, but was forced to settle for 75 percent. Even so, MDs were mightily unhappy with climbing costs for professional liability insurance. About this time, Travelers put in a bid to assume the SOCAP program, with only a 30 percent rate increase. SOCAP signed a five-year contract with Travelers beginning in 1974, just about the time the malpractice crisis exploded. By 1975 the writing was on the wall for Travelers and the Company requested a 486 percent rate increase for 1976 (it got a 327 percent hike). Late in the year, protesting the huge increases, some Southern California physicians, along with others in Northern areas, engaged in 'slowdowns' to call public attention to their problem. Remaining carriers, wary of repeating the experiences of companies like Hartford and Travelers, fled the malpractice market. But publicity about the malpractice issue led to tort reforms in the state and a back-off by some lawyers and patients intent to sue. For the years 1977 and 1978, there appeared to be a let-up in the extent of the problem. By late 1978, when the Travelers terminated its contract with

SOCAP, several doctor-created companies, including one launched under SOCAP aegis, Southern California Physicians Insurance Exchange (SCPIE), were operating.

"With Travelers out of the insurance picture in that part of the state, the unanswered question was: Should Travelers, even though its contract had been terminated, be required to meet its promise to pay back profits over five percent as specified in the initial agreement? Physicians, insisting that premiums in the 1970s had been 'exorbitant' said 'Yes'; eventually Travelers agreed to the pay-back concept. The lawsuit filed by SOCAP earlier this year was merely to buy time—to assure that the statute of limitations on the action did not run out, and possibly to bring additional pressure on the carrier to settle sooner."

William Shernoff, the attorney representing SOCAP in the lawsuit, claims that Travelers' rate increases in the 1970s netted about \$132 million over the five-year period of its contract, while payouts were projected to be only \$91 million.

Edward Zalta, M.D., President of Los Angeles County Medical Association, in the society's February *Journal* states: "To 'guesstimate' how much each of you [the physicians] who qualify by having been a policyholder of Travelers from 1976 to 1978 will receive initially, add up your [their] total premiums for the basic limits for the three years and multiply that amount times 18 percent. For instance, an orthopedic specialist who was in for all three years, paying an annual premium of \$36,000, will receive a check for approximately \$19,400 ($36,000 \times 3 \times 18\%$). A family practitioner paying \$6,000 annually will receive approximately \$3,240. The refund will be proportional to your [their] paid premium, regardless of whether you [they] were in for one, two or all three years.

"Qualifying members then will continue to receive approximately three to four percent of their premiums paid during the aforementioned years, annually through 1988, one to two percent in 1989, and then five to 20 percent in 1990, all depending on claims experience.

"Thus, 50 to 70 percent of the premiums paid by you [physicians] to Travelers in 1976, 1977 and 1978 will be refunded."

Doctors Zalta has recommended that physicians receiving refunds should return them to their patients by continuing to hold the line on fees.

DID YOU KNOW

... Medical Association of Georgia has moved to form a captive professional liability insurance company. Rates for the new company will be competitive with those of St. Paul, who currently is writing in Georgia.

... There are 25 physician-owned professional liability companies operating in 23 states which account for 37 percent of the professional liability insurance market.

... "A malpractice case costs \$10,000 to \$20,000 to bring to trial and takes two to three years to prepare," reports Texas plaintiff's attorney Jim M. Perdue. "Even a preliminary investigation costs about \$1,000. Because most lawyers can't afford to invest that amount of time and money, malpractice cases usually are steered to specialists. Specialists often won't take even a good case unless the probable damages exceed \$50,000." *Medical Economics*, February 16, 1981

... Continental Assurance Company, the commercial carrier writing physicians' liability insurance policies associated with Southern California Physician Council, Inc. (SOCAP), announced a five percent rate reduction on occurrence protection.

... Fewer, less costly malpractice suits in Indiana last year accounted for nine percent rate reductions.

... St. Paul's Fire and Marine Insurance Co. has filed to write claims-made for physicians' liability insurance with the New Jersey Insurance Commissioner.

THREE MEDICAL SPECIALTY SOCIETIES PRESENT MEDICOLEGAL SEMINARS AT ANNUAL MEETING

The Department will be co-sponsoring two medicolegal seminars at the MSNJ Annual Meeting in May.

On Sunday, May 17, 1981, a joint scientific seminar of the New Jersey Society of Anesthesiologists and the New Jersey Obstetrical and Gynecological Society will concern itself with the topic "Anesthesia in Obstetrics—Is There Room for Change?" The panel of discussants will be Robert Widows, M.D. and Joseph Cox, M.D. of the Anesthesiology Society, and Daniel Colombi, M.D. and Courtney Malcarney, M.D. of the Obstetrical/Gynecological Society. James E. George, M.D., J.D. will serve as moderator.

On Monday, May 18, 1981, the New Jersey Orthopaedic Society will sponsor a seminar concerned with "Professional Liability and the Orthopedist." James E. George, M.D., J.D. will moderate a panel consisting of Stuart Hirsch, M.D. and Ralph Cavalier, M.D. Mr. Bernard Genest, Vice President of Claims, MIIENJ will discuss "Orthopedics—Types of Loss." The video tape produced by the Department of Professional

Liability Control entitled "Professional Liability and the Orthopedist" will be shown.

SOMERSET MEDICAL CENTER TO SPONSOR MEDICOLEGAL SEMINAR

Joseph Kinney, M.D., Director, Department of Surgery and Brewster Miller, M.D., Director, Department of Medical Education at Somerset Medical Center have planned a medicolegal seminar for June 3, 1981.

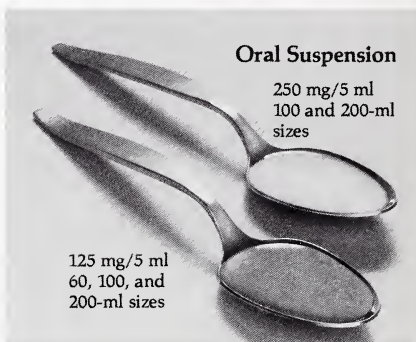
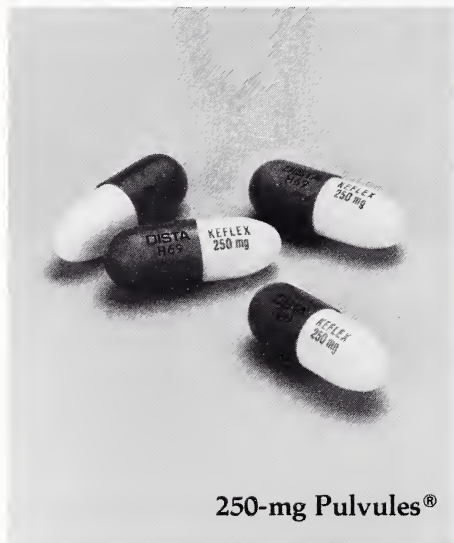
The theme of the seminar will be "Anatomy of Your Malpractice Suit." The panel includes such knowledgeable discussants as Marie Sutcliffe, claims investigator for MIIENJ, attorneys Gerald O'Connor, and L. John Dughi, and the Honorable Edward J. Seaman of the Superior Court. The seminar is designed to enhance physician understanding and awareness of the processes involved with the defense of a malpractice suit. Further inquiries may be made by contacting Brewster Miller, M.D. at (201) 725-4000, ext. 490.

BERGEN COUNTY OFFERS PROFESSIONAL LIABILITY MANUAL FOR MEDICAL ASSISTANTS

Under the direction of Ms. Joan Basic, Executive Secretary of the Bergen County Medical Society, a manual has been developed to better inform physicians and their office staff of the many pitfalls which can precipitate a malpractice suit.

The Department of Professional Liability Control of the Medical Society of New Jersey and the American Association of Medical Assistants cooperated in the production of the fifty-page manual, entitled "Reference Manual for the Physician and the Medical Assistants." Topics include: New Jersey State Board of Medical Examiners policies pertinent to medical office personnel, rules on release of patient records, issuing prescriptions and generic substitutions, the law regarding fees for filing insurance forms, a legal glossary and five articles reprinted from *Medical Economics* concerned with office personnel and their functions. The manual is free on request to Ms. Joan Basic, Executive Secretary, Bergen County Medical Society, 170 Main Street, Hackensack, NJ 07601 or call (201) 489-3140.

easy to take



Keflex®

cephalexin

Additional information available
to the profession on request.



Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

The Editor's Desk

The Editor's Desk, on which these words are being written, appears on the cover of this issue to symbolize a principle of conscious life which is very important to the medical profession—interdependence.

George Nakashima, whose mind and hands were responsible for the design and execution of this functional work of art, which was transformed from portions of a walnut tree that some would have consigned to the scrap pile, is an architect, woodworker, artist, philosopher and friend. Nakashima is internationally acclaimed for his contributions to the craft arts but he also has been recognized as one of the few remaining independent spirits to grace this nation of his birth. Had he been born and lived in Japan, the birthplace of his parents, George doubtlessly would be identified as a "national treasure."

He is a self-made man whose M.I.T. education brought credit to that university but did not interfere with the individuality of his thinking. Nakashima sees beauty in nature which transcends the ordinary eye; he appreciates and enhances the God-given qualities of the tree so as to give a second life to those pieces which are looked upon with favor by his perceptive gaze.

In his Bucks County, Pennsylvania workshop and residential compound—all of which came of his own effort—George can look back over his life which is into the eighth decade and recall the influence of worldwide travel—to India, France, Japan—and the famous and not-so-famous people whose lives have touched and perhaps influenced his own.

George Nakashima, who instinctively respects the gifts of nature, harbored a strong skepticism toward the science of western medicine, probably because of influences from his early life in India. He believed that some of the recommenda-

tions we make interfere with nature—and indeed some do—and some go contrary to natural forces—and perhaps that also is true at times. Nevertheless, through personal and family experience, Nakashima gently has adjusted his thinking and has acquired a feeling of respect, especially for the orthopedic surgeon who can give a second life to worn-out joints, through cautious application of bio-engineering, physiological, anatomical and surgical principles.

He has strong feelings about education. Nakashima believes our great universities are not educating our youth but are exposing them to superficial curricula which clone their concept of the educated person, who unfortunately is not taught the independent art of thinking. George also has a healthy disrespect for government interference in the lives of our citizens through abuse of the regulatory process. He believes executive and congressional power have their place, but like spoon-fed education, government excesses can dampen our natural instincts of self-sufficiency and freedom of spirit.

Physicians who are fortunate enough to possess a work of art by Nakashima can recognize the spirit of independence and creativity in this one-of-a-kind human being, which is akin to the spirit of independence and creativity of the medical profession.

"A tree is perhaps our most intimate contact with nature... We work this material—at times to fulfill this yearning of nature to find its own destiny, to give this absolute inanimate object a second life, even perhaps a first life. To release its richness, its beauty, to read its history and its life, to carry on this long dialogue with a board, silent, but speaking in torrents..." George Nakashima, Woodworker A.K.

Coffee and Cancer

One regularly hears these days a variation of the theme: "what difference does it make, everything causes cancer." The latest stimulus for such expressions, of course, is the epidemiological study which was reported to show a relationship between cancer of the pancreas and prior ingestion of coffee.* The inevitable extrapolation of the first release of scientific data is the numbers game which leads to such conclusions as: "the avoidance of coffee could save 10,000 lives per year."

Publication of preliminary scientific data in such prestigious weekly medical journals as the *New England Journal of Medicine* inevitably provides material for science writers for newspapers and other print media and radio and television to

present the scientific "breakthrough" of the week. There is no question that health is a very popular topic for debate and discussion among all strata of society from the academic elite to the uneducated and intellectually underendowed. One must wonder, however, what effect, if any, the release of hypothetical or incompletely documented or unsubstantiated data has on the thinking, attitudes and behavioral expressions of the recipients of such data. In short, is it good or bad to bombard the citizenry with such material?

Several questions come to mind when one considers this

*MacMahon B, et al: Coffee and cancer of the pancreas. *N Engl J Med* 304:630-633 (Mar 12) 1981.

topic:

1. What are the motives for public release of preliminary scientific data?

2. With little or no preparatory background of a scientific type, how can the recipient of such data analyze, interpret and utilize them on a personal level?

3. How should the public respond to such headline information?

4. What should the physician do with such reports—give direct advice to patients, answer questions as best he can with a minimum of established facts, or take a “wait-and-see attitude?”

5. How do the large voluntary health agencies, such as the American Cancer Society deal with this question?

6. Does government have something to say or do about all this?

One doubtlessly could arrive at many other related questions, but these will do for starters.

There can be no doubt that the media representatives love a good story and such popular topics as coffee and cancer make ideal grist for their mill. “Everyone” drinks coffee and everyone worries about cancer, so there is a limitless audience for such subjects. One cannot criticize the media for use of published scientific information because of the “right-to-know” attitude which pervades this nation. The question of accuracy of reporting or scientific significance hardly surfaces because the public even has a right to know facts that are not facts and data that are wrong! The reporter must take the material provided and paraphrase it so as to be understandable to his readers. It is not his job to verify the scientific facts—or so he says.

The scientist who publishes preliminary data cannot be faulted, or can he? At what point scientific facts become hard rather than soft or even mushy is sometimes difficult to tell. The preliminary report can put the medical and scientific community on notice that something has been uncovered and that it may or may not prove important. It lets everyone know the area of research which interests the investigators and thus represents a kind of turf-staking ritual. Should the investigator wait until data become hard? Not if he wants to justify his academic and research position and his use of public funds for research. We all like the *divulging* of a secret much better than the solo knowledge of such a secret.

The public—as a group—and its individual components are ill-equipped to handle such statements as “ingestion of two or more cups of coffee daily is associated with an upteen percent increase in cancer prevalence among Caucasian males who reside in the great northeastern section of the United States.” The public can respond only on an individual basis according to each person’s prior attitudes about research and about the health consequences of daily life-style events. It is unlikely that there will be a public clamor for or against such articles with a demand that something be done about the problems, i.e., find out the root cause of the cancer (or whatever) and stamp it out so we, the public, can get back to watching our favorite soap opera on the TV.

In many instances, the physician has not read the original article in the scientific journal before his patients begin to ask for his reaction. He, like the questioner, has only the news release as a basis for comment. He can beg the question, respond in general terms based on a visceral reaction to the topic or answer authoritatively based on prior attitudes and

personal bias. None of these is very satisfactory because patients feel that their physician ought to be the fountain of knowledge from which they can drink at will. It seems clear that the physician should anticipate such discussions in his daily patient contacts and give a calm but careful explanation—perhaps in general terms—of the role of known environmental factors to cancer causation and the possible role of coffee, as well as cigarette smoking, low fiber diets, industrial carcinogens, and so on. One cannot be all-knowing, but it is undignified for the physician to pooh-pooh the unfamiliar.

The American Cancer Society and other large voluntary health agencies may be the only winners in the public release of preliminary cancer research data. They get millions of dollars worth of free publicity which can be the stimulus for additional public contributions to cancer research. It focuses the public’s mind on cancer which, after all, is their business. Public releases on cancer show where some of the contributions are spent and suggest that the donors are getting their money’s worth and are contributing to the good of humanity. However, the American Cancer Society must be aware of potential negative effects. When daily releases suggest this or that unproven environmental factor is carcinogenic, the non-professional public tends to utilize the well-known psychonumbing technique of denial. Thus, even today, the tobacco addicts deny the dangers of cigarette smoking in the face of undeniable positive evidence. Some research purists will say that publicity of this type is bad in the final analysis because it diverts attention from the “real research” (e.g., basic scientific studies) to the level of coffee-table conversations. Such criticism does not deter the voluntary health agencies which want to stimulate a knee-jerk reflex which ends up with the checkbook and pen in hand.

Government tends to react in a way which is a bit different. The Food and Drug Administration actively is supporting the concept that the slightest clue of carcinogenic potential in environmental factors should be recognized. One needs only to remember saccharine and Sucaryl® to verify this. Their role as the protective knight in shining armor is taken very seriously by bureaucratic agencies and so it should be. The Surgeon General warns and rewarns the public about the dangers of smoking cigarettes. In all fairness, they have little choice, but the overall picture is a bit strange. How can the government warn the public against the dangers of cigarette smoking at the same time it continues to support the multi-billion dollar tobacco industry?

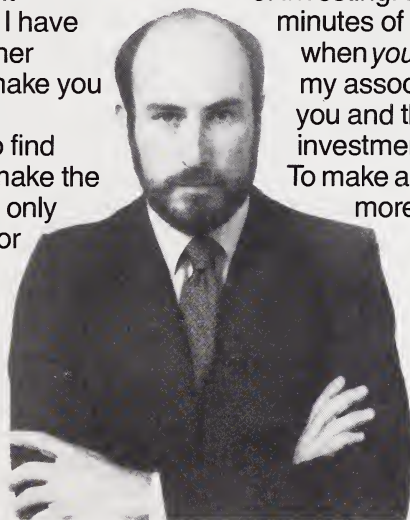
Some philosophers among the uninformed say, “You pay your money and you pick your poison.” “You have to die anyway, so why not enjoy life?” or other variations of the denial theme. Physicians cannot afford the luxury of such attitudes because they run the risk of looking and sounding very foolish. Although the role is not a comfortable one at all times, each physician must be prepared to answer questions relating to unsubstantiated scientific data in a dignified and reasonable fashion which can help his patients maintain a balance in health practices which is positive and, wherever possible, preventive. It seems quite clear that lifestyle is a major cause of morbidity and mortality. Therefore, prevention of premature disability and death may be enhanced by subtle changes in behavior. What shall replace the after-dinner cigarette and coffee? Probably something which also will prove to be a hazard. Nevertheless, research is essential and public information and education are a right. A.K.

MY SUNBELT CONDOMINIUMS CAN SAVE YOU TAXES AS SOON AS YOU BUY ONE, SHELTER YOUR INCOME WHILE YOU OWN IT, AND EARN YOU MOST ATTRACTIVE CAPITAL GAINS WHEN YOU SELL.

Now you can take advantage of what years of success in investment real estate have taught me—free.

It doesn't cost you a penny to learn about the best sunbelt condominium investments I have found for you and many other professionals. And it can make you a lot of money.

I travel the country to find condominiums I think will make the wisest investments. Select only the very best apartments for you to own. Write a report that covers all the questions good investors ask—the construction, the neighborhood, the view, and the appreciation potential. And, of course, the tax angles.



Before I recommend any condominium to you, I invest in at least one of its apartments for myself.

I'd like to tell you about my way of investing. It will take only a few minutes of your time, where and when you say, to show you what my associates and I can do for you and the health of your investment portfolio.

To make an appointment, or for more information, complete and mail the coupon below. Or, better still, call me right now at:

(201) 962-6300

Ken Gluckman
President
Skyline Associates, Inc.
72 Hickory Road
Ringwood, New Jersey 07456

FILL IN, MAIL NOW!

J-1

- ☐ Please call me to set up an appointment at no cost or obligation.
☐ Please send me more information.

Name _____ (Please print or type)
Address _____
City _____ State _____ Zip _____
Telephone () _____ () _____
office home



Skyline Associates, Inc.
72 Hickory Road, Ringwood, New Jersey 07456 • (201) 962-6300

Retired Lives Reserve

Maximize the Tax Benefits under Your Corporation's Group Term Life Insurance Plan*

WILLIAM P. SQUIRE, JR., Washington, D.C.**

The Medical Society of New Jersey recently has approved the endorsement of a new group insurance program called *Retired Lives Reserve*. The following will assist the membership to understand better the benefits of this plan and some of the tax advantages.

Many professional corporations have taken advantage of some of the tax benefits available when they establish a plan of group term life insurance for employees. These tax benefits are provided under Section 79 of the Internal Revenue Code.

1. The first \$50,000 of group term life insurance is tax free to the physician.

2. The physician is taxed on the favorable Table I rates for amounts of group term insurance over \$50,000.

3. Even though the physician may be a substandard risk, none of the extra rating paid by the corporation is taxed as additional income.

4. If the term coverage includes waiver of premium and accidental death coverage, these supplemental benefits are tax free to the physician.

5. If the corporation agrees to continue the physician's group term coverage after retirement, there is no further cost to the physician.

6. A charity can be named as beneficiary of the group term insurance. In this situation, there is no Table I cost for the group term insurance.

7. The group term life insurance death benefit itself is income-tax free to the physician's beneficiary.

8. Group term life insurance can be assigned to a third party to avoid paying federal estate taxes.

Most group term life insurance plans do not allow the physician to take advantage of the retirement benefit described in No. 5 above. This is one of the most significant (if not the most significant) tax benefit available. Most group term insurance plans either terminate completely when the physician reaches retirement age or significantly decrease the coverage. The loss of group term coverage at retirement can be very significant if a physician needs life insurance liquidity for estate planning.

Professional corporations are solving this deficiency by the addition of a *Retired Lives Reserve* to their existing group term insurance plan.

WHAT IS A RETIRED LIVES RESERVE PLAN?

Under a *Retired Lives Reserve* plan, the corporation makes payments to a special fund on an actuarially determined basis over the working life of the covered physician. The purpose of this fund is to accumulate a sufficient amount at the physician's retirement age so the fund can continue the term insurance payment for the remainder of this lifetime. The corporation has some special tax incentives to fund these postretirement term insurance benefits during the physician's working years. These include the following:

1. Each deposit to the *Retired Lives Reserve* fund is tax

deductible to the corporation. These payments are not taxed as income to the physician.

2. Interest accumulates on a tax-free basis. This is a significant point because most insurance companies are paying relatively high rates of interest on the fund accumulation.

PLAN DESIGN CONSIDERATIONS WHEN ADOPTING A RETIRED LIVES RESERVE PLAN.

As with pensions, design is the key to a good *Retired Lives Reserve* plan. Design considerations and adjustments need to be made for each corporation based on its special circumstances. The following are some of the points that have to be considered in designing a plan:

1. The corporation's current cash flow must be considered because the *Retired Lives Reserve* plan calls for current payments to the fund as well as current payments for the existing group term insurance coverage. Fund payments can be adjusted to fit the corporation's cash flow situation by adjusting the funding formula.

2. Consideration should be given to whether the *Retired Lives Reserve* plan will provide postretirement benefits for all employees in the corporation or for only a certain class of employees.

3. Consideration must be given to whether the plan will simply continue the benefits under the existing group term insurance plan or whether additional preretirement and postretirement coverage will be provided. In this regard, the physician's estate planning liquidity needs will have to be considered.

4. Consideration must be given to whether the plan should provide early retirement benefits as well as normal retirement benefits. The corporation may decide that some reduced lifetime benefit should be provided if the physician remains with the corporation for a certain minimum number of years.

The purpose of a *Retired Lives Reserve* plan is to provide the corporation with tax incentives to continue group term insurance for a physician for his lifetime. Most physicians cannot afford to have their group term insurance terminate or to pass up the income tax-free nature of this postretirement benefit.

Relatively few tax-favored fringe benefits remain after the 1976 Tax Reform Act and the 1978 Revenue Act, but this is a significant one that professional corporations should consider adding to their existing group term insurance plan.

For more information call or write: Medical Society of New Jersey, 2 Princess Road, Lawrenceville, New Jersey 08648, (609) 896-1766.

*A release from MSNJ's Department of Medical and Insurance Affairs, Joseph C. Lucci, Director. This program has been approved by the Committee on Medical Defense and Insurance, Michael J. Doyle, M.D., Chairman, and endorsed by the Board of Trustees.

**President, Professional Corporations, Ltd.

HONORABLE MARGE ROUKEMA TO SPEAK AT MSNJ ANNUAL MEETING

On Monday, May 18, 1981, at MSNJ's Annual Meeting, JEMPAC will hold two activities.

Early Monday morning, the Honorable Marge Roukema, Congresswoman from Bergen County's 7th District, will address those in attendance at JEMPAC's breakfast. The \$7.50 ticket may be purchased prior to the breakfast at the JEMPAC booth or in the registration area.

In addition to the breakfast, JEMPAC will host a wine and cheese party for all physicians and their spouses attending the Annual Meeting. JEMPAC has invited all of the gubernatorial primary candidates to meet with physicians and discuss their political platform.

A GUIDE TO GUBERNATORIAL PRIMARY CAMPAIGN FINANCING

The following is a guide to the relevant law and regulations regarding gubernatorial primary campaign financing. Specific questions may be directed to the Election Law Enforcement Commission at (609) 292-8700.

- As a general rule, any person, corporation, labor union, political action committee, partnership or other organization may contribute to the gubernatorial primary.
- No individuals or any of the aforementioned groups may contribute more than \$800 to a gubernatorial primary campaign. The candidate may contribute to the campaign but is limited to \$25,000. Contributions in any amounts up to and including \$800 must be accompanied by a signature card signed by the contributor and include name and address of candidate, and amount contributed.
- A husband and wife each may contribute up to \$800.
- "In-kind" contributions are permitted only if their value does not exceed \$800 per contributor. This includes the value of cocktail parties, billboards, helicopters, or anything else that is paid for by someone other than the campaign treasurer. If their value exceeds \$800, the excess must be returned to the contributor or paid for by the campaign. "In-kind" contributions are *not* eligible to be matched with public funds.
- A campaign may not receive any anonymous contributions; such contributions must be returned or forfeited to the State.
- The identity for all contributors of more than \$100 will be made public by the State Election Law Enforcement Commission. However, the name of *every* contributor, even those of \$100 or less, must be given to the Commission for its own confidential records.
- The campaign must raise \$50,000 before contributions will

be matched with public funds. In calculating this amount, the Commission will disregard loans, "in-kind" contributions and all but \$800 of the candidate's contributions to his own campaign. To qualify for matching funds, the \$50,000 also must be committed toward campaign expenditures.

- After the first \$50,000 is raised and encumbered, the Election Law Enforcement Commission will match each dollar of contributions with two dollars of public funds until it has paid the campaign \$600,000. The Commission will not match loans, "in-kind" contributions, or contributions beyond the first \$800 from the candidate.
- The total spending limit is \$1,050,000 (including both private and public funds). Excluded from this limit are the costs of complying with the campaign law, food and drink purchased for fund raising events, and travel expenses of the candidate.

MEDICARE AND MEDICAID PLAN

One of the proposals to cut runaway costs in Medicare and Medicaid, up from \$5.2 billion in 1970 to over \$29 billion in this fiscal year, is to dismantle the Health Care Financing Administration. The plan would call for total State control of Medicaid with federal funding contributions via grants. Medicare would go back to Social Security Administration and the PSRO program would be abolished.

MSNJ's POSITION ON PROPOSED NJ LEGISLATION

Senate-1390-Joseph Merlino, (13th District, part of Mercer)

To amend and revise the statutory charter of the Medical Society of New Jersey. **ACTIVE SUPPORT.** Assigned to: **Labor, Industry and Professions Committee:** Eugene Bedell, Chairman, James Galdieri, John Gregorio, Brian Kennedy, James Wallwork.

Assembly-1840-Bob Franks, (22nd District, part of Union and Morris) **Administrative Procedure Act Amendment.** Requires administrative agencies to prepare a fiscal impact statement before adopting or amending rules. **ACTIVE SUPPORT.** Assigned to:

Revenue, Finance and Appropriations Committee: Richard Van Wagner, Robert Janiszewski, Byron Baer, Leanna Brown, Daniel Dalton, Mildred Barry Garvin, Barbara Faith Kalik, Walter Rand, James Barry, Jr., Jane Burgio, Joseph Chinnici, Chuck Hardwick, Walter Kavanaugh, Karl Weidel.

We urge you to write to the sponsors, the committee and committee members to make MSNJ's views known—c/o the State House, Trenton, NJ 08625

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

Motrin[®] vs aspirin w/codeine...

(ibuprofen)



compare the analgesic effect

A Motrin 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients.

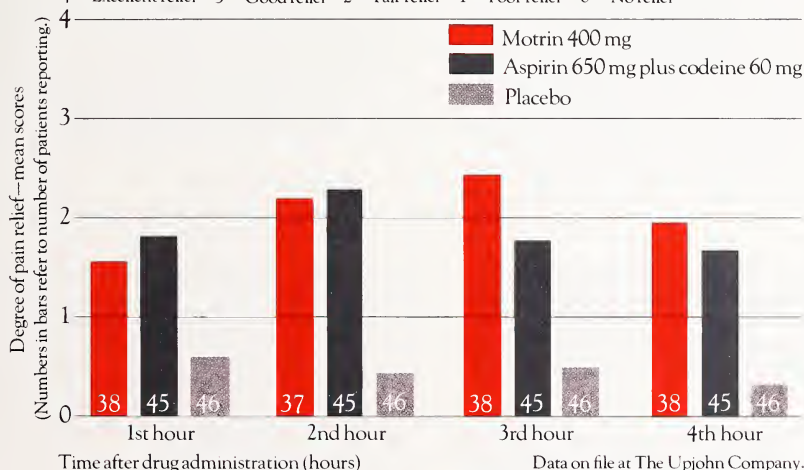
In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the Motrin and aspirin-with-codeine groups... with Motrin being significantly more effective ($p = 0.03$) at the three-hour interval.

Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief

Motrin vs aspirin-codeine combination

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



One tablet q4-6h prn

For relief of mild to moderate pain:

Motrin[®] 400mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming • Nonscheduled
- Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with Motrin is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen)

now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,^{*} epigastric pain,^{*} heartburn,^{*} diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,^{*} headache, nervousness. **Dermatologic:** Rash^{*} (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

^{*}Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

Upjohn

THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

MED B-4-S

MARCH 1981



M.D. AUTO LEASING CO.

Catering to the Medical
and allied professions

In the Greater Metropolitan
area of New York



In affiliation with
Dealers Leasing Corporation

100 Birch Hill
Albertson, New York 11507
Phone: 516-484-9670

Managing Director: Daniel A. Koweity

We are fully aware of the special circumstances of the Medical Professions and offer **THREE LEASE PLANS**, for this month.

1. '81 CADILLAC COUPE DeVILLE
 2. '81 OLDS CUTLASS SUPREME COUPE
 3. '81 BUICK SKYLARK COUPE
- or tailor one to your specific needs

SPECIAL FEATURE of the Lease Plans for physicians, dentists and pharmacists, by the M.D. Auto Leasing Company—

- Special, discounted purchase price.
- Further savings on orders of 3 or more cars in a group at any one time.
- Free Loaner Car—when your car is in for service or repair.
- Interim car at reduced rates, during waiting period.
- Optional, affordable Liability insurance plan, for one million dollars.
- Optional Quality Maintenance service, of extended warranty at modest cost.
- Convenient servicing locations of your choice.
- We make "House Calls." We come to you, right in your office or home.

M.D. Auto Leasing Comp. wants to be your own auto advisory center. Whether you want to lease or buy, to sell or exchange, or to select or decide, we have the expertise to advise you & have you save.

DISCOVER THE ADVANTAGES of leasing your next new car from—

M.D. AUTO LEASING

100 Birch Hill, Albertson, New York 11507
Phone: (516) 484-9670

The Syndrome of Lumbar Spinal Stenosis and Its Surgical Treatment*

OTAKAR R. HUBSCHMANN, M.D. and
FREDERICK J. WEISBROT, M.D., Newark

Eight patients with the syndrome of acquired lumbar stenosis were treated over a three-year period with very satisfactory results. The diagnosis rests on a careful history and physical examination and is confirmed by CT scan of the lower spinal canal and a myelogram to distinguish this condition from vascular intermittent claudication. Increased awareness of this syndrome and its exclusively surgical treatment will result in gratifying results in patients affected by this disease entity.

Many patients now reach the sixth and seventh decades while still professionally and socially active. One of the most disabling conditions affecting patients in this age group is the development of intractable lower back pain, usually ascribed to "old age."^{1,2} The back pain may radiate into the lower extremities and sometimes may be accompanied by urinary problems.^{3,4} This syndrome often is confused with vascular intermittent claudication or is thought to be due to diffuse arthritis of advanced years, since most patients have a paucity of objective findings on neurological examination, and the symptoms frequently are dismissed. In some patients, chronic treatment with analgesics, which are poorly tolerated in this age group, without any further diagnostic evaluation is instituted. Contrary to this misconception, however, the cause of this syndrome is most frequently an acquired lumbar stenosis producing multiple lumbosacral root or cauda equina compressions.^{3,5} Surgical treatment leads to very satisfactory results in a high percentage of patients.⁶ The presenting neurological findings and the radiological evaluation necessary for establishment of the correct diagnosis, based on our experience with this syndrome and its treatment over the last three years, are described in this report. This communication is intended to bring lumbar stenosis into focus, particularly among family physicians who encounter these patients frequently in everyday practice and whose initial diagnostic impression is often decisive in the final treatment or lack thereof of this syndrome.

ILLUSTRATIVE CASE REPORTS

Eight patients with this syndrome were treated surgically

at St. Michael's Medical Center and the East Orange Veterans Administration Medical Center over the last three years. The patients' age, sex distribution, preoperative symptoms, extent of surgical procedure, and postoperative results are presented in Table I. The diagnostic studies consisted routinely of plain spine x-rays in AP, lateral and oblique projections, bone scan, lumbar myelogram and, in some cases, spinal CT scan. Two typical case reports have been selected to demonstrate the salient feature of this syndrome and the diagnostic dilemmas most commonly encountered.

Case I—A 65-year-old female presented with a history of breast carcinoma treated with mastectomy five years prior to her current admission. Over the last four months before admission, she had gradually developed severe pain in the back radiating into both lower extremities, which increased with standing or walking. In view of her history, a metastatic lesion was first thought to cause these symptoms. However, radiological examination of the lumbar spine and a bone scan did not reveal any evidence of a destructive lesion. The neurological examination was negative, with the exception of bilateral ankle jerk loss and aggravation of the pain upon hyperextension. The myelogram demonstrated multiple extradural defects at levels L3 through S1. Surgery revealed a

*From the Sections of Neurosurgery and Neurology, Veterans Administration Medical Center, East Orange and CMDNJ-New Jersey Medical Center, Newark, and the Department of Medicine, St. Michael's Medical Center, Newark, New Jersey. Correspondence may be addressed to Otakar R. Hubschmann, M.D., Neurosurgery Section, Rm. 11-82, VA Medical Center, East Orange, New Jersey 07019.

Table 1

	Age and Sex	Neurological Symptoms	Neurological Examination	Level On Myelogram	Extent of Surgery	Results
1.	62F	Back pain, radiation both buttocks	Normal, positive SLR*	Stenosis, L4	Laminectomy/foraminotomy, L4	Excellent
2.	63F	Back pain, right leg pain	Absent AJ** bilaterally, decreased pin in right L5-S1, positive SLR	Stenosis, L4-S1	Laminectomy/foraminotomy, L4, S1	Excellent
3.	56F	Back pain, bilateral leg pain increased on standing	Normal, positive SLR	Stenosis, L3-S1	Laminectomy/foraminotomy, L3-S1	Excellent
4.	72M	Lower back pain, intermittent claudication	Absent AJ bilaterally, positive SLR	Stenosis, L3-L5	No surgery (declined)	No change
5.	54M	Lower back pain, diffuse leg pain, bilaterally	Weakness (4/5) in L4-S1 innervated muscles on the left, decrease in pin left L4-S1, diminished left KJ** and AJ. positive SLR	Stenosis, L1-S1	Laminectomy, T12-S1/Foraminotomy, L2-S1	Very good
6.	***56M	Back pain, left leg pain	Decreased pin S1-S4 bilaterally, absent AJ's bilaterally, positive SLR	Incomplete block, L1	Laminectomy/foraminotomy, L2-3	Fair
7.	52M	Back pain, weakness, right foot	4/5 weakness right foot, decrease pin in right L5	Stenosis, L4, 5	Laminectomy/foraminotomy, L4, 5	Very good
8.	58M	Severe pain on standing, radiation in L5-S1 distribution bilaterally	Absent AJ bilaterally	Stenosis, L3, 4, 5	Laminectomy/foraminotomy, L3, 4, 5	Excellent

*SLR - straight leg raising

**AJ, KJ - ankle jerk, knee jerk

***Post-traumatic

Excellent - No limitation of activities

No requirements of pain medication

Very Good - Minimal limitations of activities

Occasional requirement of non-narcotic pain medication

Fair - Improved from pre-op, but still significant functional limitations and requirement of narcotic pain medication

marked overgrowth of the medial articulating facets, "shingling" of the laminae, and a hypertrophied ligamentum flavum. These are all hallmarks of the syndrome of spinal stenosis. No evidence of metastatic tumor was seen. A wide laminectomy and foraminotomy were performed. Post-operatively she did very well. She was out of bed on the second postoperative day and her symptoms completely disappeared within ten days. She remained pain free and returned to her normal activities.

Case 2—A 54-year-old male presented with the chief complaint of diffuse back pain radiating into both lower extremities in what appeared to be a multiradicular pattern. On examination he had some evidence of motor and sensory involvement of L4, L5, and S1 on the left and L5 on the right, and the left knee and ankle reflexes were diminished. The bilaterality and extent of the findings were so puzzling to the admitting physician that initially there was a suspicion of malingering or at least a strong psychogenic component, particularly since the initial spinal x-rays were interpreted as showing only mild osteoarthritis. However, the myelogram revealed marked spinal stenosis and extensive bilateral root compression (Figures 1A, 2A). This was confirmed at surgery to be due to a diffuse overgrowth of both the superior and inferior articulating facets as well as diffuse narrowing of the canal by the lumbar dorsal arch. Extensive

laminectomy and foraminotomy from L2 through S1 resulted in dramatic relief of his symptoms. The patient returned to work. His postoperative myelogram demonstrated an increase in the anteroposterior diameter of the lumbar canal and freeing of the affected nerve roots (Figures 1B, 2B).

DISCUSSION

The syndrome of congenital or developmental spinal stenosis has been known for several years but only recently has its treatment become more defined.^{1,3,7-10} One of the reasons for insufficient recognition of this syndrome in general practice is the fact that the clinical presentation is often misleading.^{4,9,10} Although the complaints may be varied and often presented by the patient in a dramatic fashion, the clinical examination may be entirely normal. The salient features are neurological and radiological. The most frequent neurological complaint is lower back pain which sometimes radiates into the buttocks or into the lower extremities in a recognizable multi-radicular distribution.^{1,2,4} The pain often is made worse by prolonged standing or walking, but unlike a disc protrusion, it may not improve with bed rest.¹¹ The neurological examination may be entirely normal or the positive findings, such as a bilateral ankle reflex loss, may be of questionable significance in this age group. The patients

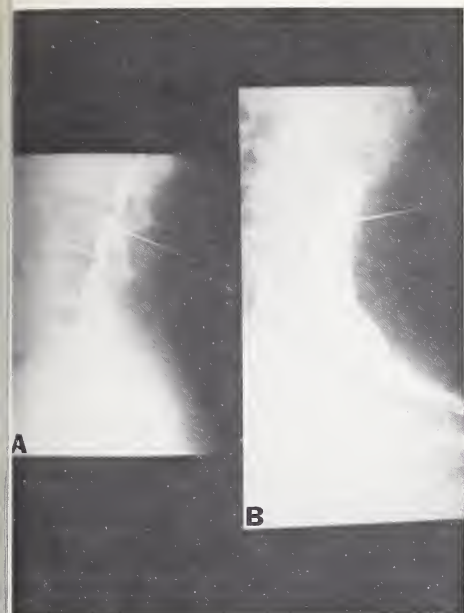


Figure 1—(A) Preoperative myelogram. The lateral view shows extensive osteophytes and narrowing of the AP diameter. (B) Postoperative myelogram shows significant enlargement of the AP diameter after surgery.

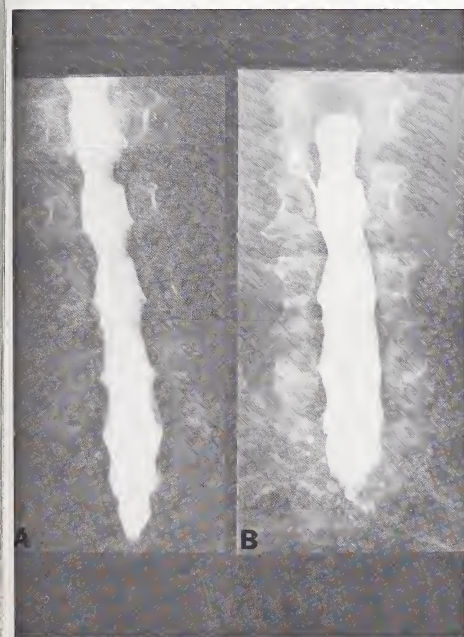


Figure 2—(A) Preoperative myelogram. The AP view shows the presence of multiple root compressions seen as filling defects. (B) Postoperative myelogram shows disappearance of the filling defects.

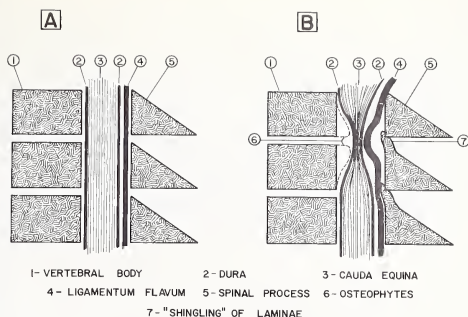


Figure 3—Schematically depicts the first mechanism of development of neurological deficit in spinal stenosis. Normal lumbar spine (A) and spinal stenosis (B). Notice the presence of osteophyte anteriorly and the infolding of ligamentum flavum which, together with "shingling" of the overgrown laminae, create the "pincer" effect.

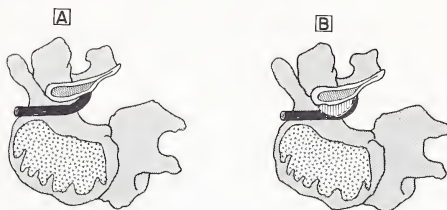


Figure 4—Shows the second mechanism of the development of neurological deficit in spinal stenosis. The normal relationship between the superior facet and the nerve root are seen in A. In B, the arthritic overgrowth of the superior facet compresses the nerve root. (Modified after Ciric *et al*: *J Neurosurg* 53:433-443, 1980).

suffering from the acquired variety of spinal stenosis usually are in their fifth through seventh decades and the primary cause is osteoarthritis. The pathogenetic mechanism of the neurological symptoms is two-fold. (Figures 3 and 4) The narrowing of the anteroposterior diameter between the vertebral body and the laminae caused by the osteoarthritic "lipping" of the vertebral body posterior edges in the form of an osteophyte or bar, combined with the overgrowth of laminae and thickening of the ligamentum flavum, produce a compression syndrome of the dura and cauda equina.^{2,5,7,10} The "pincer-like" compression becomes more pronounced in upright position due to the exaggeration of the lumbar lordosis or during walking, when patients may develop symptoms indistinguishable from intermittent claudication of vascular origin.^{4,10} The basic distinguishing features, however, between the two types of claudication, which of course may coexist in an individual patient, are the absence of back pain at rest and prompt relief of lower extremities' pain after termination of physical activity in patients with intermittent claudication of vascular origin. The second mechanism of producing the neurological deficit in neurogenic claudication which may accompany the first or be the sole cause of the complaints, is the compression of individual nerve roots by the overgrown articulating facets as

"... the treatment of lumbar stenosis requires wide and extensive removal of the laminar arch, together with a wide enlargement of the neural foramina at all involved levels. . ."

"Due to improved anesthesia the surgical procedure can be done with increasing safety, even in the oldest age group."

they traverse the neural foramina.^{2,7} The radiographic features of this syndrome, however, often are not dramatic and may be dismissed as insignificant or nonspecific in this age group. The plain x-rays often show absolute or relative stenosis of the lumbar canal but unlike x-rays of the cervical region the measurements are less accurate. Although the numbers given by various authors vary to some degree, it is generally accepted that a sagittal diameter smaller than 10 mm is diagnostic of absolute stenosis of the spinal canal, while a diameter between 10 and 12 mm is considered to represent a relative stenosis.⁷ The importance of these measurements, however, is only to alert the physician to this diagnosis because the factor that determines the presence or absence of neurological symptoms is the actual neural content to canal ratio. The myelogram, or more recently the spinal canal CT scan, therefore, is essential to establish the diagnosis as well as to determine the necessary extent of the surgical procedure.¹² The arthritic overgrowths of the articulating facets are seen on the myelogram as multiple extradural defects and can be distinguished from other lesions such as a herniated disc or a metastatic deposit.

The correct interpretation of the radiological studies is essential for an adequate surgical procedure. Unlike the treatment of a herniated disc where adequate results can be achieved through a small laminotomy leaving the dorsal arch intact, the treatment of lumbar stenosis requires wide and extensive removal of the laminar arch, together with a wide enlargement of the neural foramina at all involved levels. This procedure, which does not result in spinal instability even if it extends over several levels, is tolerated surprisingly well by most patients.¹³

CONCLUSION

The increased awareness and recognition of this syndrome among family practitioners, internists, and orthopedists, particularly those who treat older patient populations, is of great importance. Due to improved anesthesia the surgical procedure can be done with increasing safety, even in the oldest age group. Gratifying results allow these patients to return to physical and social activities previously precluded by their pain.

SUMMARY

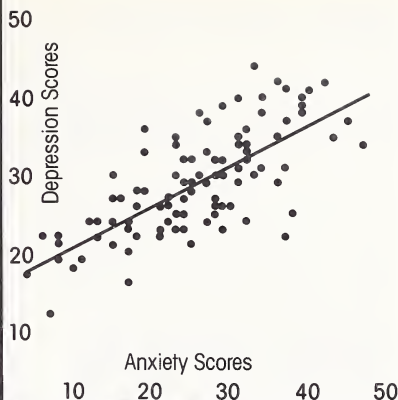
The salient features of the syndrome of acquired lumbar stenosis are back pain with or without radiation into the lower extremities, increased on walking or standing and sometimes accompanied by urinary difficulty but not re-

lieved by brief rest. The complaints often are multiple but there frequently is a paucity of objective neurological findings. The diagnosis is confirmed by computerized tomography and myelography of the spine. The radiographic hallmarks are the overgrowth of articulating facets and narrowing of the anteroposterior diameter of the spinal canal. The treatment of this syndrome of neurogenic claudication is exclusively surgical; results are quite satisfactory, even among elderly patients among whom this syndrome frequently occurs. It is our hope that awareness of this syndrome among family physicians and internists will lead to its early recognition and treatment. Eight patients with this syndrome have been treated by us in the last three years with very satisfactory results.

REFERENCES

1. Epstein JA: Diagnosis and treatment of painful neurological disorders caused by spondylosis of the lumbar spine. *J Neurosurg* 17:991-1001, 1960.
2. Epstein JA, Epstein BS, Lasine E, *et al*: Lumbar nerve root compression at the intervertebral foramina caused by arthritis of the posterior facets. *J Neurosurg* 39:362-369, 1973.
3. Ehni G: Significance of the small lumbar spinal canal: Cauda equina compression syndrome due to spondylosis. Part I: Introduction. *J Neurosurg* 31:490-494, 1969.
4. Paine KWE: Clinical features of lumbar spinal stenosis. *Clin Orthop Related Research* 115:77-82, 1976.
5. Friedman E: Narrowing of the spinal canal due to thickened lamina. A cause of low-back pain and sciatica. *Clin Orthop* 21:190-197, 1961.
6. Wiltse LL, Kirkaldy-Willis WH, McIvor GWD: The treatment of spinal stenosis. *Clin Orthop Related Research* 115:83-91, 1976.
7. Verbiest H: Neurogenic intermittent claudication in cases with absolute and relative stenosis of the lumbar vertebral canal in cases with narrow lumbar intervertebral foramina and in cases with both entities. *Clin Neurosurg* 20:204-214, 1972.
8. Epstein J, Epstein B, Rosenthal AD, *et al*: Sciatica caused by nerve root entrapment in the lateral recess: The superior facet syndrome. *J Neurosurg* 36:584-589, 1972.
9. Kirkaldy-Willis WH, Paine KWE, Cauchois J, McIvor G: Lumbar spinal stenosis. *Clin Orthop Related Research* 99:30-50, 1974.
10. Yamada H, Ohya M, Okada T, Shiozawa Z: Intermittent cauda equina compression due to narrow spinal canal. *J Neurosurg* 37:83-88, 1972.
11. Paine KWE, Huang PWH: Lumbar disc syndrome. *J Neurosurg* 37:75-82, 1972.
12. McIvor GWE, Kirkaldy-Willis WH: Pathological and myelographic changes in the major types of lumbar spinal stenosis. *Clin Orthop Related Research* 115:72-76, 1976.
13. Paine KWE: Results of decompression for lumbar spinal stenosis. *Clin Orthop Related Research* 115:96-100, 1976.

The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scales in 100 nonpsychotic psychiatric patients. The coefficient of correlation is 0.7. As depression increased, so did the anxiety levels.¹



WHY MORE PHYSICIANS ARE CHOOSING LIMBITROL

It fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician¹ found a correlation of 0.7 in anxiety and depression scores; another² has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

It is more appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression. These contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.^{2,3}

It avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Claghorn J: *Psychosomatics* 11: 138-441, Sept-Oct 1970. 2. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. 3. Baldessarini RJ, Tarsy D: Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascio A, Kilham KF. New York, Raven Press, 1978, p. 999.

in moderate to severe depression and anxiety

Limbitrol[®] IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

because it's specific for anxious depression in the nonpsychotic patient

ROCHE

Please see summary of complete product information on following page.

LIMBITROL® TABLETS ® Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperreflexic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely. The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, block tongue.

Endocrine: Testicular swelling and gynecostomy in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestations and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Large portion of daily dose may be taken at bedtime. Single p.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Packs of 50.

BARRY PARKER FOR GOVERNOR



The Republican New Jersey Needs.

Paid for by Citizens for Parker.
Elton Conda, Treasurer.

ANNUAL AWARDS DINNER of the ACADEMY OF MEDICINE OF NEW JERSEY

Wednesday, May 27, 1981
6:00 P.M.

at
THE CHANTICLER
Millburn, New Jersey
1981 AWARD RECIPIENTS

EDWARD J. ILL AWARD
JAMES A. ROGERS, M.D.

CITIZENS AWARD
ALAN SAGNER

SPECIAL HONORARY MEMBERSHIP
MORRIS H. SAFFRON, M.D., Ph.D.

For further information on registration and seating arrangements contact the Executive Offices of the Academy: Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

ROCHE
ROCHE PRODUCTS INC.
Monro, Puerto Rico 00701

Use of Antidepressants from Conception to Delivery

CHARLES GOLDFARB, M.D., Staten Island, NY
GARRETT KEATING, M.D., Plainfield*

In reviewing the literature, the danger of teratogenic effects to pregnant women from neuroleptic drugs is clear. Neuroleptics cross the placenta and present a hazard to the fetus. The history of a woman who became pregnant while on large doses of tricyclic antidepressant and an outline of the regulation of her medication are given.

We report the case history of a woman who became pregnant and delivered a normal infant while on high doses of tricyclic antidepressants. It is presented in conjunction with a review of the literature concerning the teratogenic effects of various neuroleptic drugs.

CASE REPORT

The patient is a 36-year-old married female with a 20-year history of recurrent depression. Episodes of depression occurred at ages 16, 17, 21, and 25. For the last ten years family physicians have treated her with amitriptyline with fair to good success. Past history revealed no previous psychiatric hospitalization. The patient had been pregnant and delivered successfully five times in 1966, 1968, 1970, 1977, and 1979. Amitriptyline always was discontinued during the first two trimesters of her pregnancies until 1978. During her fourth pregnancy in 1976, when amitriptyline was discontinued, her depression became more severe and suicidal ideation developed. During the third trimester of that pregnancy, amitriptyline was reinstated at doses ranging from 75 mg. to 300 mg. per day. In May 1977 she had a healthy, normal, female baby.

She had seen a psychiatrist once when she was 25, but did not return for followup because she felt it would be of no help. Family history revealed no clinical record of depression. Her father frequently was dejected but never was treated for depression. Her mother was usually pessimistic in

outlook. There was one sibling, a brother four years her senior.

When the patient was first seen in March 1977 her mental history was positive for periodic recurrent depression. Her mood and affect were appropriate and in keeping with a diagnosis of recurrent unipolar depression.

She had been educated in the use of her amitriptyline. Fifty mg. a day was her baseline dose. If symptoms of depression were mild, she was to increase the tricyclic to 100 mg. a day. If symptoms were moderate, she was to increase the dose to 200 mg. a day. If severe, daily use of 300 mg. of amitriptyline was indicated. Mild depression was defined as feeling dejected, a sad feeling without any serious sleep or ideational problems. Moderate depression referred to deep dejection, difficulty with ideation and some sleep disturbances. Severe depression referred to very deep dejection, marked sleep disturbance, suicidal ideation, and inability or difficulty in initiating activities.

In October 1977 her depression became worse and amitriptyline dosage was increased to 200 to 300 mg. a day. In

Dr. Goldfarb is former director of psychiatry, Muhlenberg Hospital, Plainfield, NJ and currently Medical Director, Mission of the Immaculate Virgin, Mount Loretto, Staten Island, NY and Clinical Associate Professor at Rutgers Medical School and New Jersey Medical School, CMDNJ. Dr. Keating is Senior Attending Obstetrician and Gynecologist, Muhlenberg Hospital and Clinical Associate Professor at Rutgers Medical School, CMDNJ. We are indebted to the patient, who is the subject of this paper, for her cooperation and the use of her diary.

“‘Thou shalt not prescribe a psychoactive drug during the first trimester of pregnancy except when absolutely necessary.’”

“... neuroleptics . . . , if clinically indicated, can be administered safely to pregnant women without a grave danger of teratogenic effects.”

September, 1978 the patient was again severely depressed and asked for a change of medication. Desipramine was tried at 150 mg. to 200 mg. a day. This regimen caused dizziness, headaches, blurred vision, marked dryness of the mouth and constipation. The patient expressed ambivalence about seeing C.G., felt that he was not helping her, questioned his “leadership in treatment,” and thought of seeing someone else. Her depression seemed as bad or worse than at the onset of treatment.

At this time, a trial of combined tricyclics seemed worthwhile; 3-methoxy 4-hydroxy phenylglycol (MHPG) levels could not be obtained because of inadequate facilities. Imipramine and amitriptyline combined therapy had been used by the treating physician several years earlier with another depressed patient. Conceivably, the patient would need a serotonin increase (amitriptyline) as well as a norepinephrine increase (imipramine) to offset her depressive symptoms. She had been on desipramine (norepinephrine increase) for ten days. Instructions were given in using imipramine with amitriptyline.

If better for three or more days, tricyclics were reduced by 50 mg. (25 mg. of each) on a daily basis until the baseline was reached. If symptoms worsened, a 50 mg. daily increase (25 mg. of each) was indicated until the patient felt better or reached a level of 300 mg. a day. She was to telephone when necessary, but at least weekly, for any improvement or worsening of symptoms. Within five days the patient reported improvement on 300 mg. total levels (150 mg. of each tricyclic).

In October, she called and stated that she was five to six weeks pregnant. She was asked to come in and was told of the possibility of congenital defects with antidepressants. She was offered a choice of amniocentesis, therapeutic abortion, or the use of electroconvulsive therapy (ECT) in lieu of tricyclics for depression. She chose to continue with the medication despite her awareness of the risks involved. She spoke of deep convictions and commitment to the principles of the Right to Life movement, and rejected all alternatives except for carrying her pregnancy to term and taking the tricyclics as needed for depressive symptoms.

She was placed on 25 mg. amitriptyline a day and was to call if any increase was necessary. In February 1979 her depression increased, and amitriptyline was increased to 75 mg. to 150 mg. daily. In March 1979 the patient felt moderately depressed and used 150 mg. amitriptyline with 50 mg. imipramine. The depression increased until the patient was instructed to use 150 mg. of amitriptyline with 150 mg. of imipramine together. This total combined regime of 300 mg. of both tricyclics helped. In the last two months of her pregnancy the patient was tired, moderately depressed, but felt better with daily naps.

In early May, the patient was advised to decrease her

tricyclics by 50 mg. a day, and stay on 25 mg. of each tricyclic until 48 hours prior to delivery. She was taking 25 mg. of imipramine on May 21, 1979 when Dr. Keating delivered her healthy, 8 lb. 2 oz. baby boy. There were no deformities, and there were no withdrawal effects from the tricyclics in the baby. The Apgar score, as performed by Dr. Keating was 10. Neonatal evaluation was perfectly normal. Pediatric follow-up to this date continues to be normal.

Following delivery, the patient showed severe depression (possibly a combined postpartum and decreased tricyclic level effect). Combined tricyclics of 150 mg. imipramine and 150 mg. of amitriptyline were reinstated, and the patient showed improvement by the seventh day after this regime was begun.

In June, July, and August her combined tricyclics ranged from 200 mg. to 300 mg. daily. This regimen has helped control her depressive symptoms and the patient feels she is better now than when only on amitriptyline.

REVIEW OF THE LITERATURE

(A) History—Ayd put it succinctly when he wrote: “The available data on the prescription of neuroleptics permit the conclusion that these drugs, if clinically indicated, can be safely administered to pregnant women without a grave danger of teratogenic effects. Nevertheless, all available neuroleptics cross the placenta and may be potentially hazardous for the fetus. Hence, one of the commandments governing rational psychopharmacotherapy should be: ‘Thou shalt not prescribe a psychoactive drug during the first trimester of pregnancy except when absolutely necessary.’ This dictum should be obeyed even if animal reproductive studies have not demonstrated teratogenic potential.”¹

More than a generation before this dictum was formulated, the basic work on thalidomide showed its devastating teratogenicity. From 1954 to 1964, studies performed with thalidomide found that the human embryo may be inordinately sensitive to a substance that causes little or no toxicity in human adults or in test animals. However, when taken by the mother during the susceptible period of embryonic development (from the 20th to the 35th day), thalidomide produced a well-defined pattern of musculoskeletal deformities, primarily in the extremities and face. These effects occurred if the drug was taken in sufficient quantities on a few days, or even a single day, during the susceptible period of human embryonic development.^{2,3}

In the late 1960s and early 1970s, the anticonvulsant drugs were incriminated in causing human teratogenesis. Many studies showed cleft lip, cleft palate, facial clefts, cardiac defects, and some increases in the incidences of abortion.⁴⁻⁸

At the same time, mouse studies on amphetamine ingestion during pregnancy revealed congenital malformations in newborns.⁹ Within seven years of this report, careful studies

were done on dextroamphetamine use by pregnant women. These studies showed that the dextroamphetamine users had infants with a higher incidence of cardiac malformations¹⁰, biliary tract atresia¹¹, and various other malformations within a control group.¹² The amphetamines had been used during early pregnancy for appetite suppression and/or dejection in the mother.

(B) Tricyclic Teratogenicity—In the 1970's the tricyclics were suspected of being teratogenic. From Australia came reports, in 1972, of a possible correlation between imipramine during the first trimester of pregnancy and the birth of a few infants with reduction deformities of the upper limbs resembling those seen with thalidomide.¹³ These findings stimulated reexamination of animal studies.

Imipramine and other related tricyclic antidepressants had showed variable teratogenicity in rabbits almost a decade earlier,¹⁴ and imipramine was indicted as a cause of teratogenicity in rats.¹⁵

The Metropolitan Atlanta Congenital Defects Program report of January-February 1972 examined 120 cases involving reduction deformities of the limbs similar to those described in Australia, but was unable to establish that any of the mothers had taken any tricyclics during pregnancy. The report concluded that if the tricyclic antidepressants have teratogenic potential in humans, it is of low order when used at recommended therapeutic doses.³ However, in 1973, only a year later, a report on a case of maternal and fetal death from amitriptyline was published by the New Zealand Committee on Adverse Drug Reactions.¹⁶ No fetal abnormalities were reported, giving further credence to low teratogenic potential in humans.

Withdrawal effects in the newborn from maternal ingestion of tricyclics during pregnancy were reported in 1974. Hill incriminates imipramine and nortriptyline as causing withdrawal symptoms such as "colic, cyanosis, irritability, weight loss, hyperhidrosis, respiratory distress . . . and urinary retention." Craniofacial, central nervous system, and skeletal abnormalities also are reported.¹⁷ In the case presented, withdrawal symptoms were absent because of judicious decrease of tricyclics seven weeks prior to delivery.

In 1975, Ananth reported a total of five children with examples of congenital defects whose mothers used psychopharmacologic agents during pregnancy which included the following: (1) three children whose mothers had taken imipramine or amitriptyline during the first trimester of pregnancy were born with *limb deformities*; (2) a newborn whose mother had been given amitriptyline during the first 12 weeks of pregnancy had *absent digits and hydrocephalus*; and (3) a newborn whose mother had taken protriptyline and diazepam for the first four months of pregnancy had *spina bifida occulta*.¹⁸ Also reported in New Zealand in the same year was a newborn with fetal malformation whose mother had taken amitriptyline.¹⁹

(C) Lithium Teratogenicity—Although primarily used for mania, lithium carbonate has been used frequently in treating depression, primarily bipolar depression. However, some physicians also use lithium for treatment of unipolar depression. Lithium toxicity in the newborn can occur within the therapeutic range taken by the mother. The infant shows cyanosis, poor suck and Moro reflexes, lethargy, flaccidity, hepatomegaly, heart murmur, elevated blood urea nitrogen, and elevated lithium levels.²⁰ One author raises the question of fetal teratogenicity in use of higher doses.¹⁸ Other authors regard lithium's potential for producing cardiovascular malformations a serious risk, to be weighed before using

lithium in pregnant or potentially pregnant women.²¹ Of 166 cases reported to the International Registry of Lithium Babies from 1968 to 1976, cardiovascular abnormalities occurred in 13 (72%) of the malformed infants.²¹ Defects consisted of congenital heart disease, tricuspid valve defects or atresia and Ebstein's anomaly. This is significant neonatal pathology, since major cardiovascular abnormalities are expected to represent only a minority of all severe congenital abnormalities.²²

Nephrogenic diabetes insipidus, euthyroid goiter, and hypoglycemia have occurred in infants born to women who took lithium during pregnancy.^{23,24}

CONCLUSION

Although psychopharmaceuticals should not be prescribed in the first trimester of pregnancy, there are occasions when they are needed. The possibility of teratogenicity is of primary concern to the treating physician. A review of the literature concerning teratogenicity and antidepressants is offered. A case history of a depressed woman who became pregnant and delivered a normal infant while on high doses of tricyclic antidepressants is presented.

SUMMARY

In a review of the literature it is clear that there is a danger of teratogenic effects when administering various neuroleptic drugs to pregnant women. All available neuroleptics cross the placenta and may be hazardous to the fetus. The authors quote Ayd in his conclusion that psychoactive drugs should not be prescribed during the first trimester of pregnancy except when absolutely necessary. They report the case history of a woman who became pregnant while on high doses of tricyclic antidepressant and delivered a normal infant. She was unaware of her pregnancy until the sixth week of gestation and was determined to carry the pregnancy to term. She rejected all alternatives and chose to continue with the medication despite the risks. An outline of the regulation of her medication is given.

REFERENCES

1. Ayd FJ: Psychotropic drug therapy during pregnancy. *Drug Therapeutic Newsletter* 11:5-12, (Feb-Mar) 1976.
2. Lenz W: Chemicals and malformation in man: Congenital malformations. *Intern Med Congress*, 1964, pp 268-276.
3. Wilson JG: Present status of drugs as teratogens. *Teratology* 1, 1973, pp. 3-15.
4. Bird AV: Anticonvulsant drugs and congenital abnormalities. *Lancet* 1:311, 1969.
5. McMullin GP: Teratogenic effects of anticonvulsants. *Br Med J* 2:430, 1971.
6. Meadow SR: Congenital abnormalities and anticonvulsant drugs. *Proc Roy Soc Med* 63:12-13, 1970.
7. Mirkin BL: Placental transfer and neonatal elimination of diphenylhydantoin. *Am J Obstet Gynec* 109:930-933, 1971.
8. Pashayan HD, Pruzansky D, Pruzansky, S: Are anticonvulsants teratogenic? *Lancet* 2:702-703, 1971.
9. Nora JJ, Trasler DG, Fraser FC: Malformation in mice induced by dexamphetamine sulfate. *Lancet*: 2:1021-1022, 1965.
10. Nora JJ, Vargo TA, Nora AH, Love KE, McNamara DG: Dexamphetamine: A possible environmental trigger in cardiovascular malformations. *Lancet* 1:1290-1291, 1970.
11. Levin JN: Amphetamine ingestion with biliary atresia. *J Pediatr* 79:130-131, 1971.
12. Nelson MM, Forfar JO: Associations between drugs administered during pregnancy and congenital abnormalities of the fetus. *Br Med J* 1:523-527, 1971.
13. McBride WG: The teratogenic effects of imipramine. *Teratology* 5:262, 1972.

14. Robson JM, Sullivan FM: Production of fetal abnormalities in rabbits by imipramine. *Lancet* 1:638:639, 1963.
15. Aeppli VL: Teratologische Studien mit Imipramin an Ratte und Kaninchen. *Arzneimittelforschung* 19:1617-1640, 1969.
16. Proceedings New Zealand Committee on Adverse Drug Reactions. *N Zealand Med J*. 79:309-316, 1973.
17. Hill RB: Will this drug harm the unborn infant? *So Med J* 67:1476-1480, 1974.
18. Ananth J: Congenital malformations with psychopharmacologic agents. *Comp Psychiat* 16:437-445, 1975.
19. New Zealand Committee on Adverse Drug Reactions—Tenth Annual Report 1975. *N Zealand Med J* 82:308-309, 1975.
20. Woody JN, London WL, Wilbanks GD Jr: Lithium toxicity in a newborn. *Pediatr* 47:94-96, 1971.
21. Scholl M, Amdisen, A, and Steenstrup OR: Lithium and pregnancy II, hazards to women given lithium during pregnancy and delivery. *Br Med J* 2:137-138, 1973.
22. Weinstein MR: The international register of lithium babies. *Drug Information J* 10:94-100, 1976.
23. Weinstein MR, Goldfield ME: Cardiovascular malformations with lithium use during pregnancy. *Am J Psychiat* 132:529-531, 1975.
24. Rane A, Bjarke B: Effects of maternal lithium therapy in a newborn infant. *J Pediatr* 93:296-298, 1978.
25. Mizrahi EM, et al: Nephrogenic diabetes insipidus in transplacental lithium intoxication. *J Pediatr* 94:493-495, 1979.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physicians Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® 5^{Buccal} / 10^{mg} / 25^{Oral} / 25^{mg}

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Delayed Hypersensitivity to Thimerosal in Contact Lens Solutions

SCOTT R. ZEIGEN, B.A., IVAN H. JACOBS, M.D.,
GEORGE I. WEINBERGER, M.D., Newark*

A case of a delayed hypersensitivity reaction to thimerosal-preserved contact lens solutions is reported. Physicians should be aware of the possibility of an allergic reaction to thimerosal in addition to a locally irritative phenomenon.

Thimerosal (Merthiolate®), a widely used preservative, is known to cause a delayed hypersensitivity reaction in susceptible patients who have been exposed to the agent in a variety of topical pharmaceutical products. That thimerosal can cause ocular irritation on a true hypersensitive basis, rather than a purely local toxic/irritative phenomenon, is less well appreciated. We were able to find only one previous case report in the English language of a hypersensitive reaction to thimerosal-containing contact lens solutions. We would like to report a patient who presented with ocular symptoms shortly after initiating the use of thimerosal-containing ophthalmic solutions.

CASE REPORT

A 25-year-old male physician initiated the wearing of hard contact lenses in November, 1976. Within days of the initial dispensing, irritation developed that was worsened by the use of cushioning drops. Watering of the eyes and pruritis were the main subjective symptoms. Examination at that time revealed the presence of a follicular hypertrophy and conjunctival injection. A review of contact lens solutions used revealed that thimerosal and benzalkonium chloride (BZ C1) were the universal preservatives. Standard epicutaneous occlusive patch testing was performed to thimerosal (0.1% aqueous solution) and BZ C1 (0.1% aqueous solution) and a control blank by the standard procedure of applying the suspected allergen to the skin under an aluminum-backed

test strip and covering the site by occlusive hypoallergenic tape for 48 hours. The sites were inspected for positive results of erythema, induration, vesiculation or bulla formation at 48 and 72 hours. The control and BZ C1 sites were negative, whereas the thimerosal site was 2+ positive with the development of induration, papules and fine vesicles at 48 hours. This reaction continued to worsen over the next 48 hours.

The past history was significant in that there once had been a local reaction which consisted of induration and intense pruritis when thimerosal was applied to an abrasion at the right shoulder.

The substitution of non-thimerosal-containing contact lens solutions completely eliminated the ocular irritation, but hard contact lenses eventually were discontinued because of fitting problems. In 1979, the patient was fitted with a thin series Bausch and Lomb contact lens. He was advised to use unpreserved saline for thermal disinfection and Bausch and Lomb daily cleaner, followed by extensive rinsing of the cleaning solution. By following this disinfecting system, there has been no recurrence of the previous irritation except for

*From the Department of Ophthalmology, New Jersey Medical School-CMDNJ (Dr. Jacobs) and the Departments of Ophthalmology (Dr. Jacobs) and Dermatology (Dr. Weinberger), Muhlenberg Hospital, Plainfield, NJ. Mr. Zeigen is a member of the Class of 1982, CMDNJ-Rutgers Medical School, Piscataway. The work was funded by Summer Fellowship Program, CMDNJ-Rutgers Medical School Teaching Laboratories. Correspondence may be addressed to Ivan H. Jacobs, M.D., Eye Institute of New Jersey, 15 S. Ninth Street, Newark, NJ 07107.

“... some patients who develop ocular pruritis and irritation may be demonstrating a cellular-mediated immune response to thimerosal.”

“Ocular irritation associated with contact lens use also may be related to a reaction to the lens material itself or to improper lens handling.”

one incidence of follicular hypertrophy associated with perlimbal conjunctival microcystic edema. This occurred after one accidental exposure to thimerosal-containing saline solution (Normol®).

DISCUSSION

This case report illustrates that some patients who develop ocular pruritis and irritation may be demonstrating a cellular-mediated immune response to thimerosal. The only reliable way to differentiate a true delayed hypersensitivity reaction from a direct irritant effect is by patch testing to the suspected allergens. In this patient, patch testing to thimerosal was positive and to benzalkonium chloride it was negative.

Other investigators previously have reported on delayed hypersensitivity reactions to thimerosal. Suzuki reported in the Japanese literature that of his patients with ocular irritation to ophthalmic solutions, half were sensitive to thimerosal by skin patch testing.¹ Moller found about five percent of patients suspected of having contact allergy to be hypersensitive to thimerosal.² Epstein reported on false positive delayed hypersensitivity reactions in intradermal testing caused by thimerosal in the diluting fluid used to prepare the allergens.³ Other studies by numerous investigators also have discussed the role of thimerosal in delayed hypersensitivity reactions.⁴⁻⁶ In 1976, in a letter to the editor, Pederson reported the only previously documented case in the English language of delayed hypersensitivity to thimerosal in contact lens solutions.⁷

That thimerosal in ophthalmic solutions can cause local irritation has been considered. Ellis postulated “severe ocular complications” could result from the use of thimerosal in ophthalmic preparations, especially thimerosal (Merthiolate®) ointment 1:5000⁸. He made his supposition because of severe dermatological reactions seen in thimerosal-sensitive patients, and was concerned about the possibility of keratitis or corneal ulceration occurring in previously sensitized patients who received thimerosal in ophthalmic preparations. However, it was not until 1969 that Sussman and Friedman demonstrated the local irritative effect of thimerosal and benzalkonium chloride in rabbit eyes following instillation every 30 minutes for 8 hours.⁹ They were able to produce varying degrees of hyperemia, lacrimation and photophobia and concluded that solutions of thimerosal (0.004%) and benzalkonium chloride (1:25,000) were profound eye irritants.

Ocular irritation associated with contact lens use also may be related to a reaction to the lens material itself or to improper lens handling. Keratoconjunctivitis has been associated with the wearing of hydrophilic contact lenses that were cleaned improperly and contained debris or had surface irregularities¹⁰ or were found to be carrying fungi along cracks in the lens surface where the lens material had broken

down.¹¹

Bernstein and Lemp reported on a number of cases of keratoconjunctivitis that occurred after the wearing of hydrophilic contact lenses for 6 to 18 months or longer.¹² Most of their patients had bilateral follicular conjunctivitis associated with conjunctival lymphocytosis. However the investigators were unable to determine the cause of the conjunctivitis but were able to rule out viral or bacterial contamination or a reaction to contact lens surface irregularities. Shnider, on the other hand, suggests that symptoms that develop after long-time use of soft contact lenses indicate possible changes in the lens substance, while problems occurring immediately after insertion indicate the lens fitting is at fault.¹³ It also has been demonstrated that some bacteria are capable of attaching themselves to the anterior surface of soft contact lenses. This possibly could lead to a local area of bacterial proliferation with susceptibility to an immunologic reaction, resulting in ocular irritation.¹⁴ Wearers of hard and soft lenses also may develop giant follicular conjunctivitis of the upper tarsal plate after months to years of contact lens use. Though the symptoms of ocular itching and increased mucus production resemble vernal conjunctivitis, the severity of these symptoms is less marked, with wearers of soft lenses generally having a more intense reaction.¹⁵

Allergy and sensitization to other ophthalmic preparations also must be kept in mind. Blepharoconjunctivitis has been associated with pilocarpine, atropine, epinephrine, physostigmine and topical penicillin.¹⁶ Other commonly used drugs, such as chloramphenicol, tetracycline, griseofulvin, neomycin and benzocaine, are known to cause allergic reactions especially with appropriate topical use.^{16,17} Ophthalmic preparations of naphazoline and cortisone also may cause ocular allergy.¹⁸

It also should be brought to the attention of each clinician that treatment of ocular irritation of unknown origin with steroid preparations must be done with great care. Possible adverse reactions to ophthalmic steroid use include development of posterior subcapsular cataracts, elevated intraocular pressure and loss of vision. There also exists the possibility of superinfection, especially with herpes simplex. These preparations should be used only on those patients in whom a clear understanding of the pathogenesis of their ocular irritation is known and should be under the supervision of an ophthalmologist.

CONCLUSION

Patients who develop ocular irritation from contact lens solutions or other topical ophthalmic agents should be evaluated for true hypersensitivity to the active agents and preservatives in all products used by standard occlusive epicutaneous patch testing. Minor irritative effects would not preclude future contact with the irritant, but in the case of

“... treatment of ocular irritation of unknown origin with steroid preparations must be done with great care.”

“... thimerosal and other organic mercurial compounds should be replaced by other less sensitizing compounds.¹⁹”

true hypersensitivity, future contact predictably will elicit a similar response. We must concur with the *Medical Letter* opinion which suggested that thimerosal and other organic mercurial compounds should be replaced by other less sensitizing compounds.¹⁹

REFERENCES

1. Suzuki S: Allergic conjunctivitis and blepharoconjunctivitis caused by thimerosal. *Jap J Ophthalmol* 26:7-12, 1972.
2. Moller H: Sensitizing aspects of preservatives. *J Biol Stand* 3:241-245, 1975.
3. Epstein S: Sensitivity to Merthiolate®: A cause of false delayed intradermal reactions. *J Allergy* 34:225-234, 1963.
4. Reisman RE: Delayed hypersensitivity to Merthiolate® preservative. *J Allergy* 43:245-248, 1969.
5. Mitzutani H: Hypersensitivity to thimerosal. *N Engl J Med* 288:1424, 1973.
6. Hansson H, Moller H: Thimerosal reaction and cell-mediated immunity. *N Engl J Med* 290:1202, 1974.
7. Pederson N: Allergy to chemical solutions for soft contact lenses. *Lancet* 18:1363, 1976.
8. Ellis FA: Possible danger in the use of Merthiolate® ophthalmic ointment. *Arch Ophthalmol* 30:625-626, 1943.
9. Sussman J, Friedman M: Irritation of rabbit eye caused by contact lens wetting solutions. *Am J Ophthalmol* 68:703-706, 1969.
10. Johnson DG: Keratoconjunctivitis associated with wearing hydrophilic contact lenses. *Can J Ophthalmol* 8:92-96, 1973.
11. Roth HW: The etiology of ocular irritation in soft lens wearers: Distribution in a large clinical sample. *Contact Lens* 4:38-47, 1978.
12. Bernstein HN, Lemp MA: An unusual keratoconjunctivitis occurring after long-time wearing of AO Softcon hydrophilic contact lens. *Ann Ophthalmol* 7:97-106, 1975.
13. Shnyder HA: The contact lens—Part 3. *J Am Optometric Assoc* 49:811-815, 1978.
14. Fowler SA, Greiner JV, Allansmith MR: Attachment of bacteria to soft contact lenses. *Arch Ophthalmol* 97:659-660, 1979.
15. Allansmith MR, Korb DR, Greiner JV, Henriquez AS, Simon MA, Finnemore VM: Giant papillary conjunctivitis in contact lens wearers. *Am J Ophthalmol* 83:697-708, 1977.
16. Tan B: Hypersensitivity and allergic reaction to ophthalmic drugs. *Aust J Optom* 57:14-21, 1974.
17. Epstein E: Allergy to dermatologic agents. *JAMA* 198:103-106, 1966.
18. Theodore FH: Drug sensitivities and irritations of the conjunctiva. *JAMA* 151:25-31, 1953.
19. *Medical Letter on Drugs and Therapeutics* 12:62-63, 1970.



***You know
what you want
in Step-1
antihypertensive
therapy...***

For your hypertensive patients,

Long-acting

Zaroxolyn[®] gives (metolazone) Pennwalt

Efficacy

Start with Zaroxolyn because of its unsurpassed effectiveness in Step-1 therapy.¹⁻⁴

Stay with Zaroxolyn because it maintains effectiveness in long-term therapy^{1,5,6}... and minimizes the need for Step-2 agents.

- ☐ Zaroxolyn's effectiveness is maintained even in the presence of reduced kidney function⁷⁻⁹

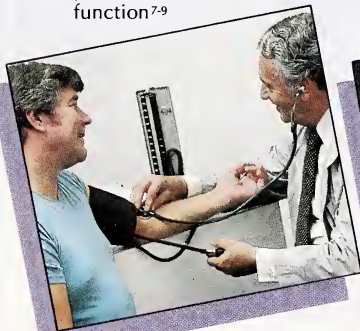
Compliance

Stay with Zaroxolyn because it maintains 24-hour blood pressure control with simple once-daily dosage, and only 4% discontinue therapy due to side effects!

Safety

Stay with Zaroxolyn because clinically significant side effects are rare!

- ☐ Low incidence of changes in serum K⁺, glucose metabolism, or uric acid levels



you what you want

Compatibility

Add to Zaroxolyn easily if Step-2 agents become necessary.

- ☐ Permits lower doses of Step-2 agents to minimize side effects
- ☐ Allows flexible dosage titration, in contrast to fixed-dose combinations

Economy¹⁰

- ☐ Less expensive than most other diuretics
- ☐ More economical than hydrochlorothiazide in fixed-dose combination with triamterene or reserpine/hydralazine
- ☐ Costs less than beta-blockers
- ☐ Less expensive than methyldopa, clonidine, or prazosin



Start with...stay with...and add to...

Long-acting

Zaroxolyn[®]

(metolazone)

Gives you what you want in
Step-1 antihypertensive therapy

Please see following page
for prescribing information.

Long-acting
Zaroxolyn[®]
 (metolazone) Pennwalt

2½ mg, 5 mg, 10 mg tablets

**Gives you what
 you want in
 Step-1 antihypertensive
 therapy**

- ☐ Unsurpassed Step-1 efficacy in mild to moderate hypertension
- ☐ True once-daily dosage for excellent patient compliance
- ☐ Positive side effect profile
- ☐ Strong foundation for stepped-care therapy
- ☐ Long-term economy

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma, allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium

depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eppena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York, Stratton, 1976, pp 221-245. 3. Flawski RM, Scheib EI, Misage JR, et al: technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotis S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dorfmeil L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Puscheck JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezzi E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book 1991*, and manufacturers' suggested prices.

R DIVISION
PENWALT
 ROCKEFELLER NEW YORK 14623

Calcium Pyrophosphate Deposition Disease: A Commonly Unrecognized Entity*

EDWARD G. MOSS, M.D., and
SHELDON D. SOLOMON, M.D., Camden

Calcium pyrophosphate deposition disease mimics many other types of arthritis. Four cases are presented which exemplify this mimicry. Two cases were not only misdiagnosed but also mistreated initially. The clinician must keep a high index of suspicion for this disease when confronted with a patient with arthritis. Synovial analysis and radiographs may reveal the true etiology of the patient's arthritis.

Approximately fifteen years ago, while examining synovial fluid from a patient who demonstrated typical clinical features of acute gouty arthritis except for a normal serum urate level, McCarty noted non-urate-appearing crystals.¹ He isolated these crystals and, utilizing x-ray diffraction and other physical chemical techniques, recognized them to be microcrystalline calcium pyrophosphate dihydrate. Utilizing compensated polarized light microscopy he was able to demonstrate that these crystals exhibited the sign of weakly positive birefringence, while the sodium urate crystals demonstrated the sign of strongly negative birefringence. He coined the term "pseudogout" because of the similar clinical features to patients with true gout. McCarty's initial series of patients seems almost identical in clinical and radiologic manifestations to a group of patients first described in 1958 by Zitnan and Sitaj.²

Over the past decade several articles have been written concerning patients with pseudogout syndrome or chondrocalcinosis. At present, the term "calcium pyrophosphate deposition disease" (CPPD) seems to be the most applicable, since the term "pseudogout" is not embracive of the various clinical pictures as seen with this problem and the term "chondrocalcinosis" is too nonspecific.

This entity can be diagnosed by identification of weakly positive birefringent crystals (either needle or rhombic shape) in the joint fluid, by compensated polarizing microscopy,

and by typical cartilage calcification in x-rays of joints. Only a probable or suspected diagnosis can be made because of the lack of one of the two diagnostic criteria in many cases. It is important to make diagnosis not only because of its diagnostic and therapeutic implications, but also because of associated metabolic diseases such as hyperparathyroidism and hemochromatosis.

CLINICAL PICTURE

The clinical picture of CPPD is extremely variable. It really could be called "The Great Mimic." About fifty percent of patients have a picture resembling osteoarthritis. This might more accurately be called pyrophosphate arthropathy. These patients have progressive degeneration of multiple joints. The knees are the most commonly affected, followed in frequency by the wrists, metacarpal phalangeal joints, hips, shoulders, elbows and ankles. Although symmetrical involvement can be present, the disease usually is more advanced unilaterally. CPPD should be considered in

*From the Cooper Medical Center, Camden, where Dr. Moss is attending radiologist. Dr. Moss also is clinical assistant professor of radiology, Rutgers Medical School, CMDNJ Piscataway; Dr. Solomon is clinical associate professor of medicine, Jefferson Medical College, Philadelphia. This article is based on a scientific exhibit presented at the annual meeting of the Medical Society of New Jersey, May 14-17, 1977, Atlantic City, New Jersey. Correspondence may be directed to Dr. Moss at Cooper Medical Center, One Cooper Plaza, Camden, New Jersey 08103.



Figure 1a—Case One—Right wrist; arrow points to articular calcification



Figure 1b—Case One—Left wrist

most cases of osteoarthritis, particularly when joints not prone to trauma are involved; e.g., the wrists, elbows and metacarpal joints.

Many cases of CPPD present in a gout-like fashion, hence the term pseudogout. These attacks are either acute or subacute and self-limiting, lasting from a few days to a few weeks. Either one joint may be involved or a cluster attack can occur after surgical procedures or physical or emotional stresses. The knee is the most commonly involved joint, analogous to the big toe in gout. However, almost any other joint in the body may be involved. When present in a monarticular fashion, septic arthritis must be ruled out.³

Approximately five percent of patients present with multiple joint involvement in a subacute, insidious fashion. These may have other signs or symptoms of inflammation such as morning stiffness, generalized fatigue or elevated sedimentation rate. These cases have been called "pseudorheumatoid arthritis" by McCarty.⁴

X-RAY FINDINGS IN CPPD⁵

The predominant x-ray finding in CPPD is calcification of cartilage (chondrocalcinosis) especially in the menisci of the knees, the triangular cartilage of the wrists and the symphysis pubis. The calcification is usually bilateral. It is coarse and floccular when fibrocartilage is involved, but linear and delicate when hyaline cartilage is involved. There also may be calcification of capsule, tendon and ligament.

The radiographic picture in pyrophosphate arthropathy is also fairly distinctive. This superficially resembles de-

generative arthritis with joint narrowing, subchondral cyst formation and sclerosis. It is often symmetrical. The knees, wrists and metacarpal phalangeal joints are most commonly involved. The intra-articular distribution may be fairly distinctive; in the wrist it involves the radiocarpal compartment and in the knee patellofemoral compartment.

In many patients the changes in pyrophosphate arthropathy may be more severe and include fragmentation of subchondral bone and thus resemble neurotrophic arthropathy. When these changes occur in the locations discussed above, the diagnosis of pyrophosphate arthropathy might be suggested even without chondrocalcinosis.

CASE ONE—(Resembles septic arthritis)

A 76-year-old female presented to our emergency room with a painful, swollen right wrist, associated with a fever of 102° F. She was admitted to the orthopedic service and a diagnosis of septic arthritis was made. Initial white blood count was 18,000, with 76% polys, 20% lymphs, 4% monos. Intravenous broad-spectrum antibiotic therapy was begun. After three days the patient still maintained a fever and had very little response. She was seen in consultation by a rheumatologist who aspirated the right wrist. One drop of fluid was removed and examined under polarized microscope. The fluid revealed positive birefringent crystals compatible with calcium pyrophosphate. X-rays of both wrists showed calcification of the joint cartilage (chondrocalcinosis) and soft tissue swelling of the right wrist (Figures 1a and b).



Figure 2a—Case Two—Right knee; arrow points to articular calcification



Figure 2b—Case Two—Left knee

CASE TWO—(Resembles gout)

A 61-year-old gentleman presented with a history of recurrent explosive joint swelling involving his right ankle, left knee and right wrist on different occasions. Each episode lasted approximately five to six days and then disappeared spontaneously. At his present visit he complained of acute swelling of his right knee, which had started the day before. The joint was aspirated and 30cc of an inflammatory fluid was removed. The fluid revealed a white count of 32,600, with 86% polys, 14% lymphs. Many weakly positive birefringent crystals were seen, compatible with a calcium pyrophosphate. X-ray revealed minimal narrowing of the medial aspects of both knees. Extensive chondrocalcinosis was present bilaterally (Figures 2a and b).

CASE THREE—(Resembles degenerative joint disease)

A 56-year-old gentleman presented who stated that he had "osteoarthritis" since the age of twelve, at which time he had pain in both hands, wrists and knees. Almost every joint in his body had been involved since this time. He had required several surgical procedures, including a wedge osteotomy of his right knee. Clinical examination did reveal osteoarthritic changes in several joints. Extensive laboratory testing was negative, including a normal sedimentation rate and a negative rheumatoid factor and normal uric acid. A small amount of fluid was aspirated from his left knee; this contained a few pyrophosphate crystals. Several x-rays were taken, revealing evidence of chondrocalcinosis in multiple joints, as reflected in the x-ray shown. Note also, the

extensive arthritis, superficially resembling advanced degenerative disease (Figures 3a and b).

CASE FOUR—(Resembles rheumatoid arthritis)

A 56-year-old gentleman presented with a three-year history of progressive pain and swelling in several small and large joints. He had been told he had rheumatoid arthritis and was given several different treatments, including gold therapy, in the past. The arthritis had been rather symmetrical and was associated with stiffness in the morning for about half an hour and afternoon fatigue. Examination revealed warmth and swelling in several joints, including several metacarpal phalangeal joints, both wrists, right elbow and both knees. Aspiration of fluid from his shoulder revealed a white count of 4,600, with 78% polys, and 22% lymphs. There were a few weakly reactive positive birefringent crystals, resembling calcium pyrophosphate. X-ray of the left shoulder showed a minimal narrowing of the glenohumeral joint space. Calcification of joint cartilage also was present (Figure 4).

COMMENT

Although originally described as a distinct clinical and radiological entity, these cases demonstrate the protean clinical and radiographic manifestations of CPPD. The cases reviewed here emphasize the necessity for maintaining a high index of suspicion when evaluating patients with either acute or chronic arthritis. In fact, two of our cases were initially mistreated. Case one was treated with antibiotics for the



Figure 3a—Case Three—Right knee; metallic staples are from previous osteotomy



Figure 3b—Case Three—Left knee

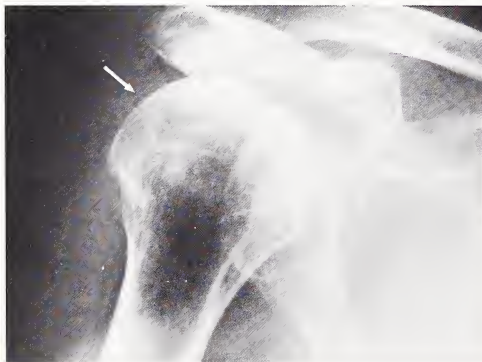


Figure 4—Case Four—Left shoulder; arrow points to articular calcification

initial diagnosis of septic arthritis; and Case four was unsuccessfully treated for rheumatoid arthritis for a prolonged period. These four patients were eventually admitted to a community hospital, where the appropriate diagnosis was made. We suggest that a high index of suspicion and ongoing dialogue between clinician and radiologist will lead to the discovery of many more patients with CPPD.


REFERENCES

1. McCarty DJ, Kohn NM, Faires JD: The significance of calcium phosphate crystals in the synovial fluid of arthritis patients: The "pseudogout syndrome." *Ann Intern Med* 56:711-737, 1962.
2. Zitnan D, Sitaj S: Chondrocalcinosis articularis. *Ann Rheum Dis* 22:142-152, 1963.
3. Doll JN, Jackson FN: Acute pseudogout simulating septic arthritis. *JAMA* 242:1768, 1979.
4. McCarty DJ: Diagnosis mimicry in arthritis: Pattern of joint involvement associated with calcium pyrophosphate crystal deposition. *Bull Rheum Disease* 25:804, 1975.
5. Resnick D: Clinical, radiographic and pathologic abnormalities in calcium pyrophosphate dihydrate deposition disease (CPPD): Pseudogout. *Radiol* 122:1-15, 1977.



**Acute pain
is no laughing matter.**

The first prescription for the first days of acute pain Empirin® \bar{c} Codeine #3


Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). 

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin \bar{c} Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin \bar{c} Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin \bar{c} Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming) 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSEAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Pseudo-Bladder Neck Syndrome in Women: Value of Gray-Scale Ultrasonography

LAWRENCE GOULD, M.D., Lyons

R. PATEL, M.D., R. BURBELLA, M.D., Newark*

An unusual case of urinary bladder outlet obstruction in a female caused by extrinsic pressure is discussed. This example of the pseudo-bladder neck syndrome is noteworthy in that the patient presented with chronic urinary retention as the direct result of pressure from the cervix of a myomatous retroverted uterus applied against the urethra and that diagnosis was aided by the use of gray-scale ultrasonography.

Myomatous uteri are fairly common in the middle-age female population and they usually can be identified by means of manual palpation. Sometimes, a large myomatous uterus can press against or even displace the urinary bladder. This can be seen in the cystogram phase of an intravenous urogram. More rarely, acute urinary bladder retention can occur when myomas present in a retroverted uterus and wedge the cervix anteriorly against the urethra.¹ Outlet obstruction caused by this type of external mechanical force has been termed the pseudo-bladder neck syndrome in women.²

Recently, we encountered a patient who was unusual in two respects: (1) she presented with *chronic* urinary retention due directly to the pressure of the cervix of a myomatous retroverted uterus against the urethra, and (2) the differentiation of a capacious bladder from other abnormalities was made possible by gray-scale ultrasonography.

CASE REPORT

A 41-year-old female was referred to the gynecology clinic of Martland Medical Center on March 14, 1978 with a complaint of increased abdominal girth, pedal edema and low back pain, which gradually had become worse over the previous two months. An abdominal mass about 24 weeks gestational size was palpated on physical examination. A firm, knotty, immobile retroverted uterus with a severely wedged anterior cervix could be felt on pelvic examination.

The clinical impression was retroverted myomatous uterus with an associated mass.

Ultrasonography performed on March 15, 1978 showed a 20 x 16 cm. cystic mass which arose from the pelvis and extended superiorly. The uterus could be identified as a separate structure, just below its inferior border (figures 1 and 2). A large distended bladder was considered to be present, but an ovarian cyst could not be excluded based on this study alone.

Postvoiding echograms were not obtained since voluntary efforts by the patient to urinate followed by attempts to catheterize, were both unsuccessful. Intravenous urography on March 17, 1978 did show, however, that the large cystic mass was the urinary bladder (figure 3). A barium enema on March 20, 1978 demonstrated that there was obstruction to the retrograde flow of barium, an unexpected finding since there had been no complaints of fecal impaction or constipation (figure 4).

On March 23 the patient was examined under anesthesia, and this time catheterization was accomplished successfully with drainage of 3300 cc of urine. The mass was noted to shrink to 18 weeks gestational size. Laparotomy then was

*Dr. Gould is Chief, Radiology Service, Veterans Administration Medical Center, Lyons, and Clinical Associate Professor of Radiology, CMDNJ, New Jersey Medical School, Newark. Drs. Patel and Burbella are Assistant Professors of Obstetrics and Gynecology at the college. Correspondence may be addressed to Dr. Gould at the VA Medical Center, Lyons 07939.

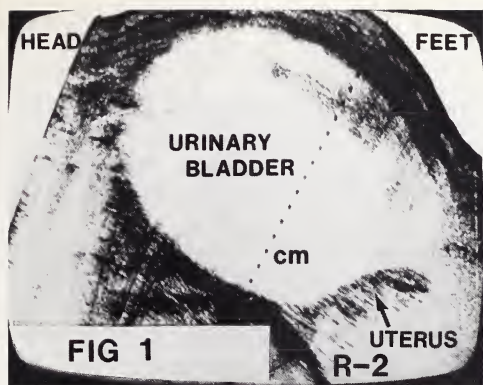


Figure 1—A longitudinal echogram 2 cm. to the right of the midline demonstrating a large (20 x 14 cm.) bladder. The uterus is seen inferiorly.

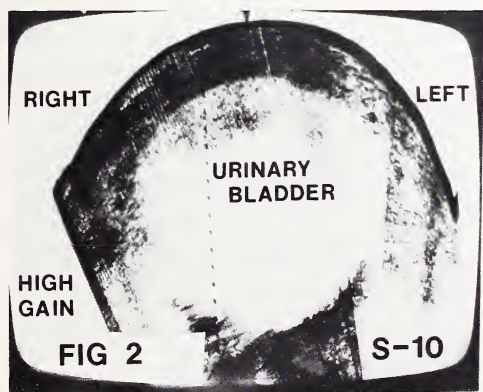


Figure 2—A transverse view 10 cm. above the symphysis pubis showing the bladder using high gain technique.

performed and an enlarged retroverted uterus studded with myomas was seen; it was attached to a huge, hypertrophied bladder by means of multiple, dense adhesions. The procedure was terminated and definitive surgery was postponed until such time when satisfactory involution of the bladder could be attained. In order to help accomplish this goal, urecholine was prescribed in doses of 25 mg., q.i.d. In October 1978, cystography revealed a notable reduction in bladder size. Extensive endocrine and neurological evaluations were normal. A total abdominal hysterectomy and bilateral salpingo-oophorectomy were performed on October 24 without complication.

DISCUSSION

The pseudo-bladder neck syndrome in women produces urinary bladder retention by stretching or by compressing the urethra. If a myoma is located in the anterior part of the cervix, it can interfere with normal micturition by pressing upon the urethra. If a myomatous uterus is retroverted in position, normal voiding also can be blocked by anterior displacement and wedging of the cervix against the urethra or bladder neck.³

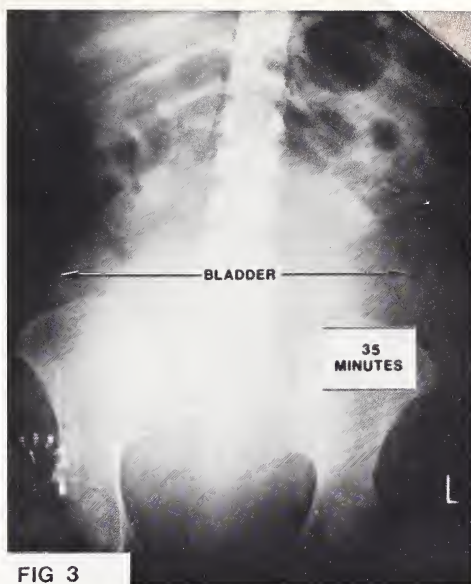


Figure 3—Intravenous urogram film at 35 minutes confirming that the large cystic structure is the urinary bladder.

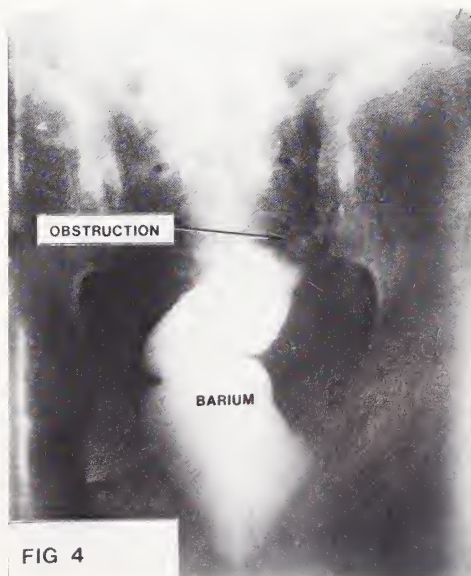


Figure 4—Barium enema film demonstrating that there is retrograde obstruction to the flow of barium because of the mass.

Acute urinary retention with signs of urgency and frequency have resulted from these processes. Chronic retention can develop if the signs of acute retention are neglected, but our patient experienced neither frequency nor overflow incontinence. Despite the obstructive pattern seen on the barium

"Gray-scale ultrasonography . . . can localize and measure the size of a pelvic cystic mass."

" . . . gray-scale ultrasonography can be beneficial in cases of urinary retention caused by solid masses which are located inside the bladder . . . "

enema, she did not even complain of constipation and her neurological profile was normal.

Gray-scale ultrasonography can assist in the evaluation of the pseudo-bladder neck syndrome in women. First it can localize and measure the size of a pelvic cystic mass, then, after catheterization and urine drainage, ultrasonography can prove the cystic mass is the bladder, since an ovarian cyst will not get smaller. Ultrasonography also can be of value in identifying other lesions which are known to cause extrinsic outlet obstruction. These include hematocolpos, pelvic abscesses, ovarian tumors, uterine malignancy, gravid retroverted uterus, and fecal impaction.⁴⁻⁷

Finally, gray-scale ultrasonography can be beneficial in cases of urinary retention caused by solid masses which are located inside the bladder, and obstruct the opening to the proximal urethra. Examples of this would be calculi, tumors and foreign bodies. These entities would appear as echogenic densities contained within, and surrounded by the clear echo-

free fluid of an enlarged bladder. These indicate an *intrinsic* cause for the urinary retention.

REFERENCES

1. Youssef AF: *Gynecological Urology*. Springfield, Illinois, Charles C. Thomas, 1960. p. 619.
2. Ward JN, Lavengood RW, *et al*: Pseudo-bladder neck syndrome in women. *J Urol* 99:65-68, 1968.
3. Polsky MS, Agee RE, *et al*: Acute urinary retention in women: Brief discussion and unusual case report. *J Urol* 110:541-543, 1973.
4. Wilson DA, Stacy TM: Ultrasound diagnosis of hydrocolpos and hydrometrocolpos. *Radiol* 128:451-454, 1978.
5. Lawson TL, Albarelli JN: Diagnosis of gynecologic pelvic masses by gray-scale ultrasonography: Analysis of specificity and accuracy. *Am J Roentgenol* 128:1003-1006, 1977.
6. Cochrane WJ, Thomas MA: Ultrasound diagnosis of gynecologic pelvic masses. *Radiol* 110:649-654, 1974.
7. Uhrich PC, Sanders RC: Ultrasonic characteristics of pelvic inflammatory masses. *J Clin Urol* 4:199-204, 1976.

Pyogenic Liver Abscess Secondary to a Toothpick Penetrating the Gastrointestinal Tract*

FARHAD RAFIZADEH, M.D., HARVEY SILVER, M.D.,
STANLEY FIEBER, M.D., Livingston

An unusual case is reported of a toothpick perforating the duodenum, penetrating into the liver, and forming a liver abscess. The patient responded well to drainage of the hepatic abscess, removal of the foreign body and to antibiotics.

Intraabdominal abscesses secondary to perforation of the gastrointestinal tract by ingested foreign bodies are not rare. Nearly two-thirds of the cases involved the cecum, appendix and ileum. A variety of foreign objects have been described, half being pins, wire and nails; a third being bones; and the remainder wood splinters. Dentures and alcoholic intoxication decrease sensory perception of the palate and thus increase the risk of foreign body ingestion.¹

Penetrating foreign bodies, e.g., wood, pins and bristles, have been reported in slaughtered animals. Because of the anatomical relation between the pig's stomach and the right lateral lobe of the liver and the bovine reticulum and the left lobe of the liver, abscess formation in the liver may occur.²

Pyogenic hepatic abscess may result from a variety of causes (Table).³ However, pyogenic hepatic abscess secondary to a foreign body penetrating the gastrointestinal tract is unusual. Review of the world literature has produced four cases of penetration of a foreign body through the pyloroduodenal region with migration into and formation of a liver abscess—pin,^{4,5} fishbone,⁶ chicken bone.¹ A fifth case of a hepatic abscess with a protruding toothpick was found at autopsy. The site of penetration could not be ascertained.⁷ The presentation of a sixth case of a hepatic abscess secondary to foreign body (toothpick) forms the basis for this discussion.

CASE REPORT

On admission to the hospital (9/14/79), a 52-year-old male

complained of upper abdominal dull pain of a ten-day period. It was accompanied by low-grade fever for three days and nausea and vomiting for one day. The pain became increasingly severe and localized to the right upper quadrant. The patient was treated with cimetidine, a bland diet and erythromycin with equivocal results.

The past history included myocardial infarction in 1971 and a peptic ulcer in 1974. The patient was maintained on propranolol hydrochloride, isosorbide dinitrate and acetosalicylic acid on a daily basis.

On physical examination, the patient was noted to be in acute distress due to pain and tenderness in the right upper quadrant. Eructation was apparent. Temperature was 102°F orally, pulse 80 and respirations 20. Laboratory data revealed a white blood count of 17,100 (polymorphonuclear leukocytes 57%, stabs 22%, lymphocytes 7%, and monocytes 15%), hematocrit 44.5, sedimentation rate 42, total protein 6.4 gm/dl, total bilirubin 1.8 mg/dl, LDH 293 lu/l, SGOT 65 lu/l, serum amylase 26 u/dl, and fasting blood sugar 163 mg/dl. Three blood cultures were sterile.

Chest and abdominal roentgenograms were normal. After ingestion of six Telepaque® tablets, the gallbladder did not

*From the departments of surgery and medicine, St. Barnabas Medical Center, Livingston, NJ. Dr. Rafizadeh is senior resident in surgery; Dr. Silver is associate attending in medicine; Dr. Fieber is senior attending surgeon and clinical associate professor of surgery, New Jersey Medical School, CMDNJ. Correspondence may be addressed to Dr. Rafizadeh, 181 Parsonage Hill Rd., Short Hills, NJ 07078.

Table 1
Etiology of Pyogenic Hepatic Abscess
 (modified after DeBaakey and Jordan³)

- I. Extension of infection from contiguous structures.
 - a. cholangitis.
 - b. cholecystitis.
 - c. penetration from gastroduodenum.
 1. ulcers.
 2. foreign bodies.
- II. Hematogenous
 - a. via portal vein.
 - b. via hepatic artery.
- III. Primary hepatic lesions
 - a. trauma
 - b. malignancy.
- IV. Idiopathic or cryptogenic.

visualize. A clinical diagnosis of acute cholecystitis was made. Sepsis increased despite treatment with cephalosporin and gentamycin.

On 9/20/80 a laparotomy was performed through a right paramedian incision. The second portion of the duodenum was adherent to an abscess cavity in the anteromedial aspect of the left lobe of the liver. One hundred fifty milliliters of gray, cloudy material drained through a Foley catheter which was anchored into the cavity. Probing the adjacent liver produced a 4.2 x 0.3 cm. fragment of a toothpick. Cultures of the abscess produced streptococcus group IV, nonenterococcus.

Postoperatively, the patient responded well to a six-day treatment of chloramphenicol and ampicillin with supportive care. A gastrointestinal x-ray series showed widening of the duodenal loop and edema of the mucosa. A "fistulogram" through the Foley catheter revealed no communication between the abscess cavity and the gastrointestinal tract.

Upon further interrogation, the patient admitted eating Swedish meatballs with a toothpick at a cocktail party a few months previously.

DISCUSSION

Symptoms of pyogenic hepatic abscess may be due primarily to involvement of the liver itself, the systemic response to hepatic sepsis, or the inflammatory process from which the hepatic abscess originated. The symptomatology is insidious and protracted. Fever, malaise, weakness, weight loss

"Treatment consists of drainage of the abscess, removal of the foreign body and administration of appropriate antibiotics."

and abdominal distention are common. Pain, usually dull and constant, occurs commonly over the hepatic area. Enlargement of the liver and tenderness in the hepatic area are the most constant physical signs.

Pyogenic hepatic abscess characteristically is associated with leukocytosis which generally varies in degree with the acuteness of the pyogenic process. Alkaline phosphatase, LDH and total bilirubin may be increased. Roentgenographically, the diaphragm, particularly on the right, may be elevated with limitation of motion. Despite the availability of ultrasound, nucleide scanning, angiography and computed axial tomography, identification of liver abscesses remains a challenge. Unfortunately, most cases are diagnosed at laparotomy after prolonged observation.

Treatment consists of drainage of the abscess, removal of the foreign body and administration of appropriate antibiotics. Surgical drainage in these cases is performed best transperitoneally since a solitary abscess is anterior or anterior-inferior in the right or left lobes of the liver. There was no mortality following the surgery in four of the cases. The fifth case died of sepsis during medical therapy.

CONCLUSION

An unusual case is reported of a toothpick perforating the duodenum, penetrating into the liver, and forming a liver abscess. The toothpick was removed and the abscess drained successfully. This represents the sixth case of foreign body which penetrated the gastrointestinal tract and caused a liver abscess.

REFERENCES

1. Berk RN, Reit RJ: Intraabdominal chicken-bone abscess. *Diagnos Radiol* 101:311-313, 1971.
2. Thornton H: Foreign bodies in organs of slaughtered animals. *Veterinary Record* 95:342-343, 1974.
3. DeBaakey ME and Jordan GL Jr: Surgery of the liver, in Schiff L (ed): *Diseases of the Liver*, 4th ed. Philadelphia, Lippincott, 1975, pp. 1080-1146.
4. Abel RM, Fischer JE, Hendren WH: Penetration of the alimentary tract by a foreign body with migration to the liver. *Arch Surg* 102:227-228, 1971.
5. Ward A and Ribchester J: Migration into the liver by ingested foreign body. *Br J Clin Pract* 32:263, 1978.
6. Aron E, Roy B, Groussin P: Abscess of the liver caused by fish bone. *Presse Medicale* 74:1957-1958, 1966.
7. Morris RW: Liver abscess. *JAMA* 114:2369-2370, 1940.

"Symptoms of pyogenic hepatic abscess may be due primarily to involvement of the liver itself, the systemic response to hepatic sepsis, or the inflammatory process from which the hepatic abscess originated."

Nephrocutaneous Fistula*

ALEXANDER S. KARFOPOULOS, M.D., WILLIAM MURRAY, M.D.,
and FREDERICK J. STONE, M.D., Perth Amboy

We report a most unusual case of calculous pyelonephritis complicated by both nephrocutaneous and nephroenteric fistula formation. So far as we can ascertain, this is one of the very few cases of nephrocutaneous fistula reported in literature.

We report, here, a case of nephrocutaneous fistula. Although spontaneous fistula formation to paranephric organs¹ and skin² are described in textbooks, we have been able to locate only a single previous report of nephrocutaneous fistula³ in the recent literature. That case, like ours, represented a complication of longstanding, calculous pyelonephritis.

CASE REPORT

A 69-year-old female presented with a complaint of left flank pain subsequent to a fall and injury to that area. Approximately ten years prior to this episode she had experienced left flank pain which had been diagnosed as "arthritis" and treated with aspirin.

Physical examination revealed a small, tender swelling below the twelfth rib, adjacent to the sacrospinalis. An intravenous pyelogram revealed a non-functioning, contracted left kidney containing a multifaceted staghorn calculus.

One week following her presentation, the skin over the flank swelling broke down and purulent material began to drain. A sinogram (Figure 1) revealed a sinus tract to extend from the skin to the collecting system of the left kidney.

The left kidney was explored. A fistula tract through a traction diverticulum connected the proximal descending colon to the anterior surface of the renal pelvis. This was dissected free. The entire extra-renal tissue, including the left

adrenal gland and portions of the posterior peritoneum and a large segment of the left ureter, was dissected. This was done because of dense adhesions of the above tissues to the kidney due to chronic inflammation. During performance of the procedure a fistula tract extending from the renal pelvis through the psoas muscle to the flank skin was encountered and resected. The patient's postoperative course was uneventful.

The external surface of the pelvis of the resected left kidney was markedly irregular, red and granular. A probe could be passed through a small opening into the lumen of the pelvis. The cut surfaces showed the pelvis to be filled with irregular, brown calculi. There was marked expansion of the peripelvic fat with only a narrow band of light brown renal parenchyma appreciable grossly (Figure 2). Microscopically, there was marked chronic pyelonephritis with near complete atrophy of the renal parenchyma. A tract, lined by granulation tissue containing abundant neutrophils, extended from the pelvis through the perinephric fat adjacent to the renal cortex (Figure 3). The separately resected fistula tract was lined by similar inflammatory tissue with hyperplastic squamous epithelium lining its cutaneous terminus.

This case report is from the Perth Amboy General Hospital where Dr. Karfopoulos is Chairman of the Department of Urology, Dr. Murray is Attending Surgeon, and Dr. Stone is Attending Pathologist. Correspondence may be addressed to Dr. Karfopoulos at 663 Brace Avenue, Perth Amboy, NJ 08861.



Figure 1—(A) Lateral view, sinogram. A narrow column of contrast material extends from a pool in the soft tissues to the renal pelvis.

(B) A-P Sinogram. The column of contrast extending from the subcutaneous pool to the renal pelvis is better appreciated in this view.

COMMENT

This case represents, so far as we can determine, the second example of nephrocutaneous fistula reported in the

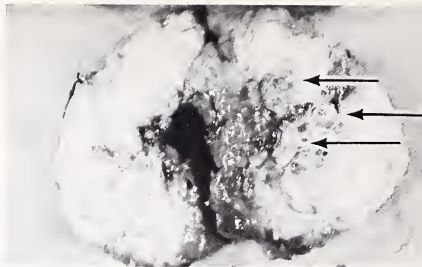


Figure 2—Hemisected Left Kidney. Only a thin peripheral band of renal tissue remains. The pelvis contains faceted calculi (arrows). The peripelvic fat is greatly expanded in volume, leaving only a thin (gray) rim of residual parenchyma.

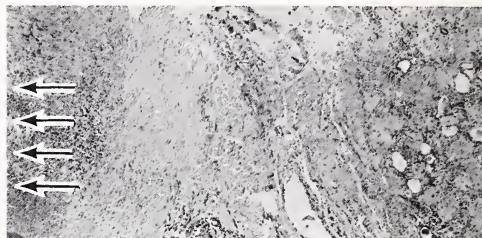


Figure 3—Microscopic. The fistula tract (arrows, left) was lined by fibrous granulation tissue, heavily infiltrated by neutrophils. The kidney (right) was end-stage with tubular dilation, chronic interstitial inflammation and vascular sclerosis.

recent, referred literature. As in the case previously reported, this fistula represented a complication of calculous pyelonephritis. It differed from that case in that a nephroenteric fistula also complicated the pyelonephritis. Nephroenteric fistulae arise most often secondary to inflammatory disease in the kidney, as opposed to the involved bowel segment. Passive adhesion of a bowel loop to the involved kidney precedes the rupture which forms the communication.

That this fistula terminated at the skin rather than in the pelvis, along the course of the psoas muscle, may be due to interaction of flank trauma with the ongoing process in the kidney. One might speculate that the tissue disruption by hematoma formation provided a path of lesser resistance than did the fascia investing the psoas.

REFERENCES

1. Goodwin WE: Surgery of urinary enteric fistula, in Whitehead ED (ed): *Current Operative Urology*. New York, Harper and Row, 1975, pp 754-781.
2. Kelalis Panayotis P. Fistulas and sinuses, in Emmett JL (ed): *Clinical Urography. An Atlas and Textbook of Roentgenographic Diagnosis*. Philadelphia, Saunders, 1964, pp 1180-1181.
3. Das S, Ching V: Nephrocutaneous sinus. *J Urol* 122:232, 1979.

Ezra Mundy Hunt—Physician, Writer, Humanitarian*

SAM ALEWITZ, Clementon

Dr. Ezra Hunt, a native of New Jersey, practiced a humanist's philosophy in an age when property rights and "the survival of the fittest" were the norm. His constructive criticism of hygienic conditions in the state led the way to the establishment of public health standards for the nation and for the State Board of Health in New Jersey.

Ezra Mundy Hunt was born in 1830 and died in 1894. During his 64 years, 42 of which were spent in the medical profession, he became the mainspring for the growth and development of the Board of Health and sanitary reform in New Jersey. Called the father of rural sanitation by the American Public Health Association, and praised by sanitarians, he remains an obscure physician today.

Hunt's life spanned from the political democracy of the Jacksonian era through the degradation of slavery and the Civil War, and matured in the period of social Darwinism in the Gilded Age; he died at the beginnings of the progressive era. While in Europe, the period of his birth was marked by national revolutions in Poland, Greece, and the Netherlands.

EDUCATION AND EARLY CAREER

In 1849 he was graduated from Princeton College, with the words of Rudolph Virchow, pathologist, anthropologist and political savant, still echoing in the medical world:

*"... Medicine is a social science, and politics nothing else than medicine on a large scale ..."*¹

Dr. Hunt wove these words into the fabric of his own social outlook. It was this social philosophy that created a basis for a program of public hygiene in the state of New Jersey.

Upon his graduation from Princeton, Dr. Hunt embarked

on a medical career. His preceptor, Dr. Abraham Coles, was an eminent physician and writer from Newark, N.J. While apprenticed to Dr. Coles, he attended lectures at the College of Physicians and Surgeons in New York City and was graduated in 1852 with an M.D. degree. He returned to his home in Metuchen and, in 1853, he was invited to teach materia medica and chemistry at the Vermont Medical Academy. His stay at the school was a brief one and, in 1855, he returned to practice in Metuchen, where he remained until his death.

SLAVERY AND HUMAN RIGHTS

Moved by patriotism and humanitarianism, Hunt enlisted in 1862 as a surgeon in the 29th New Jersey Infantry for a nine-month period. He saw action and then was transferred to the Calvert Street Hospital in Baltimore. Although he was not an abolitionist, Dr. Hunt saw evil in slavery and during the ante-bellum period he was moved by the plight of the blacks. "States' rights," wrote Hunt on his return from military duty, "quail before human rights. The war finally will be won when it is fought in behalf of human rights and

*Read before the first meeting of the Medical History Society of New Jersey, October 8, 1980, Rutgers Medical School, Piscataway. Mr. Alewitz is a retired graduate engineer who is completing a dissertation on "Sanitation and Public Health in Philadelphia, 1870-1900" at Case Western Reserve University, with David Van Tassel as his advisor. He may be addressed at 1725 Hybrid Place, Clementon, NJ 08021.

justice, and only then would the Union have the right to ask God to intervene in their behalf."²

In 1870 he called attention to his position, at a meeting of the Medical Society of the State of New Jersey, when he filed a minority report in favor of having black physicians admitted into the American Medical Association. "Your delegate being one of those," Dr. Hunt told his audience, "that have never sympathized with the tendency to equalize the political status of the Negro." He then went on to say that so long as the Negro physicians had "... certified competency and character ..." they should be admitted into membership of the AMA, especially since the medical profession had enough problems in dealing with "... the irregularities of pretense and quackery, and false creeds of doctoring, without drawing ethnological distinction"³

SEVENTY-FIRST MSNJ PRESIDENT

In 1864 Ezra Hunt was elected President of the Medical Society of New Jersey. In his inaugural address, he paid homage to the New Jersey physicians who had contributed to the well-being of the state's residents. He promised to devote himself to the destruction of disease and seek longevity for all family members, so that "... all the sweet amenities that render life a social, holy joy, may be prolonged as much as the instability of the world will permit" He proclaimed that old age was living testimony of good health and that it was more personal than inherited characteristics. He also recognized that social traumas had an adverse effect on the life expectancy of the people, a position he maintained throughout his lifetime.

At a meeting of the Committee on Public Health of the Medical Society of New Jersey in 1866, Hunt made a motion to establish a Sanitary Commission that would guide the State bureaucracy regarding the control of disease. As Chairman of the Committee, Hunt recognized that there were no immediate prospects of securing general health laws, but that there was a need to educate both the physician and general public on matters of public welfare. It was Hunt's contention that "... he who remedies a disease is a benefactor, but he who remedies the cause of a disease takes a grander step upward in the pathway of science, and the physician who is infused with the true spirit of his profession and who studies its most material progress will not forget to view it in this two-fold aspect"⁴, educating public opinion and elevating sanitary reform.

SANITARY REFORM

There was no question that the state of New Jersey needed sanitary reform. Newark, Jersey City, and Camden were the only cities that had any standard of sanitary control. Dr. Hunt said, in 1867, much more "remains to be done in them."⁵ In a major address before the Medical Society, Hunt noted that a major problem existed: that the larger cities and rural districts were inseparable. He had anticipated the megalopolis which all urban planners talk about so glibly today. "Especially in such a state as New Jersey," he said, "where cities touch towns; and towns, villages; and the villages are almost in speaking distances; it is vain to talk of proper protection of cities, without extending modified power over sparser localities."⁶ The medical profession and city and state authorities generally responded to epidemic conditions which were frightening in their swiftness, but in 1873, Hunt found it necessary to point out that conditions in the state were such that in the aggregate, thousands more were killed in rural areas by disease than by the ravages of

epidemics in the city.

During the tenure of his activity, the State of New Jersey was plagued by disease, illness and death and, in this regard, it was no different than most states. Cholera was a constant threat, and the length of the New Jersey shoreline made quarantine difficult, if not impossible. Pigs mingled freely with visitors at prosperous seashore cities, while the stink from open sewers, poudrette operations, and filthy streets mingled with the smell of perfumes and colognes. Typhus struck the "unworthy poor" in the almshouse of Camden, while in Princeton the wealthier students and their faculty were struck with typhoid by that insidious device euphemistically called "the circular water system." This was explained so ably by an old Elizabethan poem:

"So while little Toby was washing her rump
The ladies kept drinking the water out of the pump."⁷

This was a common enough occurrence in an age where the privy and water well were in close proximity and no steps were taken to prevent the mixing of the sewage and water supply.

Dr. Hunt was not satisfied with sitting in his office and reading reports which were directed to him, and then making judgments. He personally made his way from one end of the state to the other, investigating the unsanitary conditions and illnesses and offering help and advice to all who would listen. It was obvious to those involved in public health in those locales where physicians, sanitarians, and conscientious citizens formed a body devoted to public hygiene that disease was more apt to be contained and illness and death reduced. Dr. Hunt did not hesitate to make public this state of affairs.

When New Orleans and Memphis were struck with devastating epidemics of yellow fever, Dr. Hunt immediately wrote to say that the lesson would be enough to help correct the unsanitary evils of both cities and that if New Jersey continued to foster and allow the same conditions, it would be faced with the same results. Fully aware that the state could not expect voluntary efforts to remove dangerous unsanitary conditions, Dr. Hunt called for state intervention to safeguard the welfare of the people. "It has come to be generally acknowledged," said Hunt, "that some system of sanitary police is demanded for all large cities."⁸

MEDICAL STANDARDS: GOVERNMENT OR SELF-REGULATION

In the early 1800s, when the pursuit of happiness and government stewardship for the public good were still viable political realities, the members of the medical profession sought the aid of government to insure a fair standard by which to judge medical expertise.

By the middle of the century many physicians thought it wiser to find the remedy within the profession. Dr. Samuel Jackson of Philadelphia, in the 1850s, called for self-regulation—"... government within government; wheels within wheels; such is all perfect machinery"⁹ Many argued, in the days of laissez-faire, that the profession had no right to impose its will, that a man had a right to choose his own brand of medicine, whether regular, sectarian, or quack. Dr. Oliver Wendell Holmes went so far as to say, "A man's ignorance (of medicine) is as much his private property and as precious as his family bible,"¹⁰ while Lemuel Shattuck, a pioneer in the field of public health, condemned the low standards of the medical profession, and decried the right of physicians "... to cure or kill ..." without fear of recrimina-

tion because "... it's a free country ..."¹²

Dr. Hunt voiced his opinion on the matter as early as 1867 when he pointed to England and France where there was government control over the education of physicians. In New Jersey there had once been standards for the proper training of the physician, but by 1867 these laws had been annulled. Moreover, Hunt went on to decry the state of medical affairs and to say that the highest form of philanthropy was to secure legislation for the common good of society. "Why not laws?" he asked. "Why should disease, any more than any other felony, be permitted to run riot by daytime, especially when more than half of it can be prevented?"¹³ Therefore as early as 1867, although an elder of the first Presbyterian Church of Metuchen and steeped in deep Christian ethos of self-regeneration, he slowly moved from the notion of Christian voluntarism: "... moral persuasion and information," he wrote, "will not keep people from crime unless aided by law; nor is it any more reasonable to expect that good advice will cleanse the loaded air; the reeking gutters or other sources of disease."¹⁴ "Furthermore," he argued, "the state and municipalities must give to competent health officials the power to enact and put into practice admitted principles of preserving good health ..."¹⁵ in order that the death rate drop.

It must be remembered that competency in the medical profession was open to wide debate and discussion. In an age where the people and their legislators flocked in search of nostrums because they had lost faith in the medical profession, Hunt's work was made more difficult. He was no less enthusiastic, however, in pursuing his goal of acquiring a body of law to assure the welfare of the people in New Jersey. He was not discouraged: "There are cities in the United States today," he said, "where health administration, in spite of all its embarrassments, has achieved results notable and grand."

ECONOMIC ASPECTS OF PUBLIC HYGIENE

To attract the attention of the lawmakers, the business community, and the reform element of the state, Dr. Hunt pursued the timeworn path taken by many public health advocates. He took recourse in the economic aspects of public hygiene. In the Gilded Age there was no more a pleasant tune to attract attention than one preceded by the ring of money saved in taxes and municipal expenses. We have "... money enough to chase a pestilence," he said, "but not a cent to investigate its cause or deal with diseases all over the land, which is like washing hearses, buying coffins, and hiring gravediggers and mourners, for the victim of small pox, while Jenner is refused a pittance to prevent it."¹⁶ Hunt complained that the state spent hundreds of thousands of dollars to check epidemics but hardly a penny to keep them from starting. Like the 16th and 17th century medical sociologists and economists, Dr. Hunt saw poverty and disease as the enemy of the state. For him, the greatest capital in the world was a healthy population. "The people," Dr. Hunt said, "this is the strength, this is the power."¹⁷

The efforts of Dr. Hunt to create viable health organizations through the state, which were devoted to the principle of prevention, was a slow, thankless task. Hunt was aware that he had to overcome thousands of years of institutionalized medical practices before his dreams could be brought to fruition. For the most part, physicians were followers of Asclepius, the healer, with a liberal sprinkling of quacks and charlatans, who had assumed the mantle of Panacea, while a small group of enlightened physicians were

followers of Hygieia. "Hygieia, the daughter of Asclepius," he said, "shall yet have her temple to which women shall bring better offerings than the consecrated tresses of their hair, and men give more practical and productive gifts than did Pericles when he erected a statue to her."¹⁸ "So far as health is concerned," he said, "the great error both of individuals and government, and I may also say, of medical men, has been that they have looked with too great exclusiveness to the means of curing diseases, and have not associated with it enough of the ideas of prevention."¹⁹

PREVENTION

Dr. Hunt was enough of a pragmatist to recognize that in the final analysis it was the community that continued to foster that attitude, since they wanted to have available anyone who claimed the power to cure disease. It was Dr. Hunt's position that no physician should be allowed to practice "... who had not been thoroughly schooled in the act of prevention ...". He even went so far as to suggest that the physician "... cannot merely know something about sanitation in general, but must make it an integral part of the art of medicine."²⁰ However, Dr. Hunt, the idealist, was also the product of a pragmatic age and understood its effect on the medical profession. "Men in medicine," he said, "are more impressed with medicine as a business, than with it as an art." And he referred to many of them as "Yankee tradesmen."²¹ At the same time, he was aware of the need of "... the innocent and philanthropic ..." doctors, as he so aptly characterized them, to earn a living so that it did not surprise him that they directed their attention to the treatment of disease.²² It was left to him to express candidly his feelings about the attitude of the community toward the physician sanitarian:

"If he confines himself to clearing up those nuisances," wrote Dr. Hunt, "he will have a following and some applause when the stench ceases. If he ventures largely to prevent, he himself, is prevented. Between politics and legislation and the unconscious ignorance which most men have of practical possibilities of sanitary reform as a personal, civic and national blessing, is he not between an upper and nether millstone?"²³ (an old fashioned rock and a hard place).

He publicly lamented the fate of a physician who is forced to let nine die in the name of expediency so that the tenth may live. And how easy it was to become a radical when a jury of sanitarians would find him guilty, that his "... moral heroism was saving all that is precious to the people and to the children who in the next generation are to be the nation."²⁴ Hunt was not pedantic and transcended the philosophical and academic lessons of public hygiene and sanitary reforms. He was well versed in practical hygiene and wrote extensively on every facet of plumbing, heating, ventilation, and drainage. If some of his ideas were not exactly correct for 1980, they certainly were more than applicable for 1880. Had his recommendations been applied, many thousands of New Jersey lives would have been saved. He looked upon the technology of sanitation as *materia medica*. He held that the true physician was in charge of the physical welfare of the people and that nothing that relates to preventive medicine should be foreign to his occupation; that, in fact, there was more than enough knowledge available for the benefit of the people which was not put into practice or into municipal regulations.

"God in his infinite providence," he wrote, "had in operation laws that if applied would secure greater health and happiness to humanity. But ignorance or vice negated

these plans and the result was disease and illness."²⁵

On the whole, he recognized the division between the physician and the hygienist; it was this difference that no doubt prompted many physician-sanitarians to establish the American Public Health Association in 1872 at Long Branch, New Jersey, an organization in which Dr. Hunt was an active participant. "The physician deals with great afterthought," said Dr. Hunt, "the hygienist with greater forethought; and forethought is generally better than afterthought; that the sanitarian must understand his environment; air, heat, light, water, food, cleanliness, and filth, so that they may be controlled. Therefore, many a physician," he stated emphatically, "finds he has to be a sanitarian because he wants to be a good physician."²⁶

Dr. Hunt's efforts in behalf of public health were monumental; not only did he seek to apply the practical knowledge that was available, but more important, he sought to break down the social barriers that impeded hygienic progress.

In a period when poverty was a sin and disease and early death its penalty, and "... the survival of the fittest ..." was a viable social philosophy, it was difficult to convince state and municipal authorities that it was filth that was the sin. Early in his career Dr. Hunt recognized that if he were to succeed in implementing health measures, it also would be necessary to conduct an educational campaign to change the social attitudes of the state toward the poor and working peoples. "Men moralize over the survival of the fittest and limitation of life," he cried, "as if the infinite Father had something to do in a conservative way with the breaches of his holy, just, and beneficent laws." It seems to me we feel this the more, "... because emigration will make up the deficiency ..."²⁷ Dr. Hunt condemned this attitude, not only as a bad philosophy, but needlessly extravagant and immoral. When immigrants threatened to inundate the state, he evidenced the fears of the middle and upper classes that these immigrants would tend to destroy American perpetuity; that it was a patriotic duty to prevent the "mongrelization" of the native population. But he tempered his feelings by stating that this could occur only by ignoring the health of the immigrants. By securing good health, "... to the children of foreign and native parents ..." the state could enjoy "... prosperity, patriotism as well as personal comfort ..."²⁸

When typhus struck the "unworthy poor" in the almshouse in Camden, he did not condemn the poor, but rather those who permitted the intolerable conditions of filth and overcrowding to exist. He had long maintained that position. "Disease or invalidity in some forms," he had written earlier, "is the background of illiteracy, of pauperism, of crimes, of race degeneracy. As ill health," he further wrote, "is largely preventable, a radical way of dealing with the distempers of social life is to prevent this."²⁹

Sacredness of life was his underlying social philosophy, and his life was devoted to this cause. In this he joined a long list of distinguished physicians and sanitarians who had advocated social justice as a measure of public health for the benefit of the people. It is not necessary to check his medical expertise. Many of the views he held would prove, in time, to be inaccurate. It is enough to say that he met and worked with the finest members of his profession in the cause of public hygiene. He pursued, passionately, the enactment of laws for the public good. It is enough to know that he broke down social barriers and made progress a reality; that it was the filthy streets, the crowded homes, and polluted water, and stinking sewers that were the sin. For eighteen years he worked for the State Board of Health and saw many of his

recommendations enacted into law, but many more ignored or neglected. Nine years after Dr. Hunt's death, William H. Allen, another notable in pursuit of social reform, and the General Secretary of the New Jersey State Charities Association, reminded his readers, in an article entitled "Sanitation and Social Progress," that "the limit to sanitary progress was to be found in social theories ...", and in hopes of a response, "that none is so mean as to not wish a higher standard of life."³⁰

FINAL WORD

But it must be left to Dr. Hunt to have the final word. In 1867 he pleaded with the members of the Medical Society of the State of New Jersey to join with him:

"It is grand to meet sickness," he said, "and to cure maladies which we find developed, but it is grander to remedy morbid causes instead of morbid effects, and with kindred desires of philanthropy and learning to reach out in behalf of the dissemination of those correct views of human life which enable us to dry up some of the sources of human ailment. Reform in this direction must find its first and finest friends in among the practitioners of medicine and have, as it then will, the aid and countenance of all those who as civilians take broad and intelligent views of those conditions of health which are necessary to promote the welfare of the state no less than that of the citizen."³¹

BIBLIOGRAPHY

- Allen WH: Sanitation and social progress. *Am J Socio* 3: 631-643, 1903.
- Hunt EM: *The War and Its Lessons* New York, F. Somers, 1862, p 24.
- Hunt EM: President's address. *Transactions of The Medical Society of New Jersey*, 1865, pp 11-42.
- Hunt EM: President's address. The public health. *Transactions of The Medical Society of New Jersey*, 1867
- Hunt, EM, et al: Report of committees. *Transactions of The Medical Society of New Jersey*, 1868.
- Hunt EM: The need of sanitary organization in villages and rural districts. *Public Health Papers and Reports of the American Public Health Association*, Vol 1, 1873.
- Hunt EM: Hygiene: Its scope, its progress and its leading aims. Presidential address. *Public Health Papers and Reports of the American Public Health Association*, Vol. 9, 1883.
- Hunt EM: Health and social science; *J Soc Sci* 18:29-43, 1884.
- Hunt EM: How to study an epidemic. *Public Health Papers and Reports of the American Public Health Association*. Vol. 4, 1877-1878.
- Jackson S: Address. *Proceedings of the Medical Society of the State of Pennsylvania*, 1850.
- McLaughlin T: *Dirt: A Social History As Seen Through the Uses and Abuses of Dirt*. New York, Stein and Day, 1971.
- Young J: *The Toadstool Millionaires: A Social History of Patent Medicine in America Before Regulation*. Princeton, Princeton University Press, 1944.

FOOTNOTES

1. Sigerist HE: *Landmarks in the History of Hygiene*. London, Oxford University Press, 1956, p 65.
2. Hunt EM: *The War and Its Lessons*. New York, F. Somers, 1862, p 24.
3. Hunt EM: "Minority report of delegates to the American Medical Association meeting of May 3-5, 1870." *Transactions of the Medical Society of New Jersey*, 1870, pp 31-36.
4. Hunt EM: President's Address. *Transactions of the Medical Society of New Jersey*, 1865, pp 11-42.
5. Hunt EM, et al: Report of committees. *Transactions of the Medical Society of New Jersey*, 1868, pp 24-26.
6. Hunt EM: The public health. *Transactions of the Medical Society of New Jersey*, 1867, pp 57-76.
7. Ibid, p. 73.
8. McLaughlin T: *Dirt: A Social History As Seen through the*

Uses and Abuses of Dirt. New York, Stein and Day, 1971, p 108.

9. Hunt EM: The need of sanitary organization in villages and rural districts. *Public Health Papers and Reports of the American Public Health Association*, 1: 491-498, 1873.

10. Jackson S: Address. *Proceedings of the Medical Society of the State of Pennsylvania*, 1850, pp 41-55.

11. Young JH: *The Toadstool Millionaires: A Social History of Patent Medicine in America Before Regulation*. Princeton, Princeton University Press, 1974, p 70.

12. Ibid. p. 56.

13. Hunt, *The Public Health Papers*, p 71.

14. Hunt, *The Public Health Papers*, p 70.

15. Hunt, *The Public Health Papers*, p 70.

16. Hunt EM: Hygiene: Its scope, its progress and its leading aims. Presidential Address. *Public Health Papers and Reports of the American Public Health Association*, 9:1-21, 1883.

17. Hunt EM: Health and social science. *J Soc Sci* 18:29-43, 1884.

18. Hunt EM: How to study an epidemic. *Public Health Papers*

and *Reports of the American Public Health Association*, 4: 173-189, 1877-1878.

19. Hunt, *The Public Health Papers*, p 59.

20. Hunt, *Hygiene*, pp 12-13.

21. Hunt, *President's Address of Medical Society of New Jersey*, 1865, p 25.

22. Hunt, *The Public Health Papers*, p 61.

23. Hunt, *Hygiene*, p. 21.

24. Ibid. p 21.

25. Ibid. p 5.

26. Ibid. p 10.

27. Hunt, *Health and Social Science*, p 37.

28. Ibid. p 52.

29. Ibid. p 31.

30. Allen WH: Sanitation and social progress. *Am J Socio* 8: 631-643, 1903.

31. Hunt, *The Public Health Papers*, pp 74-75.

Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to decrease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgeable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche)®, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® diazepam/Roche

Before prescribing, please consult complete

product information, a summary of which follows:

indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. Geriatric or debilitated patients: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500. Tel-C-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

ANNUAL AWARDS DINNER of the ACADEMY OF MEDICINE OF NEW JERSEY

Wednesday, May 27, 1981
6:00 P.M.

at

THE CHANTICLER
Millburn, New Jersey

1981 AWARD RECIPIENTS

EDWARD J. ILL AWARD
JAMES A. ROGERS, M.D.

CITIZENS AWARD

ALAN SAGNER

SPECIAL HONORARY MEMBERSHIP

MORRIS H. SAFFRON, M.D., Ph.D.

For further information on registration and seating arrangements contact the Executive Offices of the Academy: Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

This information is compiled by the Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Arnold and Marie Schwartz College of Pharmacy and Health Sciences, Long Island University.*

1. Can antibiotics reduce the effectiveness of oral contraceptives?

It has been suggested that a drug-drug interaction between oral contraceptives and some popular antibiotics may result in reduced effectiveness of the antifertility agent.¹ The mechanism suggested involves decreased reabsorption of estrogens from the gut as a result of antibiotic-induced changes in intestinal flora.² In addition, enhanced estrogen metabolism due to microsomal enzyme induction has been demonstrated with rifampin.³

Reimers reported that treatment with rifampin (sold as Rimactane®, Rifadin® and others) resulted in 68 cases of menstrual irregularities and five cases of unplanned pregnancies among 88 women on oral contraceptives.⁴

Dossetor observed three cases of unplanned pregnancies in women receiving oral contraceptives which may have resulted from concomitant ampicillin (sold as Penbritin®, Polycillin®, Principen®, Amcil® and others) administration.⁵

Pulkkinen *et al.* based on studies involving estriol plasma levels and urinary estriol excretion, suggested a possible interaction between oral contraceptives and neomycin (sold as Mycifradin® and others) or penicillin V (sold as Ledericillin VK®, Pfizerpen®, V-Cillin®, Pen-Vee-K® and others).^{6,7}

Stone reported that among patients receiving oral tetracycline (sold as Achromycin®, Panmycin®, Robitet®, Sumycin® and others) for acne treatment, five experienced menstrual irregularities and amenorrhea.⁸ Similar reports of a possible interaction between chloramphenicol (sold as Chloromycetin® and others), sulfonamides, nitrofurantoin (sold as Furadantin®, Macrodantin®, and others) and oral contraceptives are in the literature.⁹

Friedman indicated, based on a placebo-controlled study involving human volunteers, it was not likely that ampicillin diminished effectiveness of oral contraceptives.²

In conclusion, evidence to support or dispute interaction between oral contraceptives and antibiotics is far from conclusive. However, it may be prudent to caution patients about the possibility of decreased oral contraceptive effectiveness during antibiotic therapy. This caution may be particularly advisable for patients receiving rifampin.

REFERENCES:

1. Anon: *Physicians' Desk Reference*, 34th Ed., Oradell, N.J., Medical Economics Co., 1980, p. 1595.
2. Friedman CI, *et al.*: The effect of ampicillin on oral contraceptive effectiveness. *Obstet Gynecol* 55:33-37 (Jan) 1980.
3. Back DJ *et al.*: The effect of rifampicin on the pharmacokinetics of ethinylestradiol in women. *Contraception* 21:135-143 (Feb) 1980.
4. Reimers D, *et al.*: Rifampicin, "Pill" do not go well together. *JAMA* 227:608 (Feb 11) 1974.

5. Dossetor J: Drug interactions with oral contraceptives (letter). *Br Med J* 4:467-468 (Nov 22) 1975.

6. Pulkkinen MO, Willman K: Reduction of maternal estrogen excretion by neomycin. *Am J Obstet Gynecol* 115:1153-1154 (Apr 15) 1973.

7. Pulkkinen MO, Willman K: Maternal oestrogen levels during penicillin treatment (letter). *Br Med J* 4:48 (Oct 2) 1971.

8. Stone SP: Tetracycline-irregular menses (letter). *J Am Acad Derm* 1:151 (Aug) 1979.

9. Stockley I: Interactions with oral contraceptives. *Pharmaceut J* 216:140-143 (Feb 14) 1976.

2. Is there a significant difference in incidence of gastrointestinal injury associated with different forms of aspirin?

The damaging effect of aspirin on the gastric mucosa has been well documented.¹ Of particular interest is whether or not buffered or enteric-coated aspirin can decrease the incidence of mucosal injury observed with regular aspirin.

Silvoso *et al.* evaluated the incidence of mucosal injury in 82 patients with rheumatic disease who were receiving chronic aspirin therapy.² Six percent of patients on enteric-coated aspirin developed mucosal damage compared to 23 percent and 31 percent respectively for the regular and buffered-aspirin treated groups.

Lanza *et al.* administered therapeutic doses of regular, buffered and enteric-coated aspirin or placebo to 20 volunteers.¹ Although the various forms of aspirin utilized produced similar serum salicylate levels, the regular and buffered aspirin caused significantly more mucosal damage than the enteric-coated form or placebo.

Hoftiezer and co-workers studied nine normal volunteers receiving either regular or enteric-coated aspirin.³ They concluded that regular aspirin causes a greater amount of mucosal damage than does enteric-coated aspirin.

In conclusion, regular, buffered and enteric-coated aspirin produce similar salicylate levels, but the enteric-coated form causes a lower incidence of mucosal damage. Enteric-coated aspirin appears to offer an advantage over the other forms of aspirin for patients taking large doses of aspirin on a chronic basis.

*The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm. D.; H.L. Kirschenbaum, Pharm. D.; D. Roseman, R. Ph.; D.M. Biondi, R.Ph.

REFERENCES

1. Lanza FL, Royer GL, Nelson RS: Endoscopic evaluation of the effects of aspirin, and enteric-coated aspirin on gastric and duodenal mucosa. *N Engl J Med* 303:136-138 (Jul 17) 1980.
2. Silvoso GR, *et al*: Incidence of gastric lesions in patients with rheumatic disease on chronic aspirin therapy. *Ann Intern Med*, 91:517-520 (Oct) 1979.
3. Hoftiezer JW *et al*: Comparison of the effects of regular and enteric-coated aspirin on gastroduodenal mucosa of man. *Lancet* 2:609-612 (Sep 20) 1980.

3. Can naloxone reverse diazepam's effects?

Naloxone (sold as Narcan®) is a pure narcotic antagonist used in treating overdoses of opiates. Recently it has been suggested that naloxone was useful in reversing the coma and respiratory depression associated with an overdosage of diazepam (sold as Valium®), a benzodiazepine derivative.

Several animal studies have suggested that high doses of naloxone may antagonize diazepam effects.^{1,2}

Moss first reported on naloxone's reversal of apnea occurring after a combined ingestion of a barbiturate, alcohol, and diazepam.³

Bell reported successful reversal of a confirmed acute diazepam intoxication in a 27-month-old child by naloxone.^{4,5}

Christensen *et al* performed a doubled-blind, placebo-controlled study in 46 subjects to investigate naloxone's potential to reverse diazepam-induced sedation.⁶ No significant difference between naloxone and placebo was noted.

In conclusion, although isolated case reports and some animal studies suggest that naloxone may be useful in treating respiratory depression associated with overdoses of diazepam, a controlled study has not supported this observation.

REFERENCES

1. Ho AKS, Ho CC: Toxin interactions of ethanol with other central depressants: Antagonism by naloxone to narcosis and lethality. *Pharmacol Biochem & Behav* 11:111-114 (Jul) 1979.
2. Walz MA, Davis WM: Experimental diazepam intoxication in rodents: Physostigmine and naloxone as potential antagonists. *Drug Chem Toxicol* 2:257-267 1979.
3. Moss LM: Naloxone reversal of non-narcotic induced apnea. *J Am Coll Emerg Physicians* 46-48 (Jan/Feb) 1973.
4. Bell EF: The use of naloxone in the treatment of diazepam poisoning. *J Pediatr* 87:803-804 (Nov) 1975.
5. Bell EF: Letter to the editor re naloxone reversal of diazepam effects. *Anesthesiol* 53:264 1980.
6. Christensen KN, Huttel M: Letter to the editor re naloxone does not antagonize diazepam-induced sedation. *Anesthesiol* 51:187 1979.

Selected Abstracts with Comments

Sarrazin E, et al: Dose-dependent kinetics for theophylline: Observations among asthmatic children. *J Pediatr* 97:825, 1980

Sarrazin *et al* present a paper in which 200 patients with childhood asthma, who chronically had been receiving oral theophylline preparations, were analyzed. Of these patients, 42 were found in which at least two peak serum concentrations had been measured at different doses of the same theophylline preparation. In 30 of these 42 patients the percent change in serum concentration exceeded the percent change in dose by more than 50. Three hundred additional charts were reviewed and identified a total of 26 more patients with three steady-state serum concentrations at three different doses. Of the 26 only five demonstrated a linear relationship between dose and serum concentration. The other 21 patients demonstrated disproportionate changes in serum concentration incompatible with first order kinetics and compatible with parallel first order and dose-dependent kinetics. Thus, in the present study, clinically important dose-dependent kinetics for theophylline was found in 10 to 15 percent of children. Careful monitoring of theophylline levels coincident to changes in theophylline dosage is important in order to avoid disproportionate changes in serum concentrations with the consequent risk of toxicity during continuous therapy.

Comment: The demonstration of dose-dependent kinetics for theophylline adds theophylline to an ever-increasing number of substances that have metabolic pathways for deactivation which are "saturable." This honor is shared with alcohol, aspirin, coumarin, propanalol and methotrexate, to name a few. It is clear that this presents a risk to children on theophylline. Underlying disease may render some children particularly prone to theophylline toxicity because of decreased metabolic pathways. Under these circumstances, any dosage change may result in a disproportionate increase or decrease in serum concentration rendering a child at risk for toxicity or subtherapeutic levels. This is, indeed, an important revelation.

(S. Marcus, M.D.)

Burkitt D, et al: Dietary fibre in under- and overnutrition in childhood. *Arch Dis Child* 55:803, 1980

Diets in developing countries contain much larger quantities of undigestible fibre than do those in western nations. The diet of an industrial nation is characterized by relatively high levels of refined carbohydrate and fat. As a result, children in developing nations receive a limited caloric intake and malnutrition has resulted. The western diet has resulted in a rising incidence of obesity, which can be expected. Other conditions to have emerged in western nations as a result of their low-fibre, high-energy diet and include: constipation, appendicitis, diverticular disease of the colon, hemorrhoids,

hiatus hernia, gallstones, atherosclerosis, diabetes, and perhaps large bowel cancer. It would appear, then, increasing use of foods which contain undigestible fibre in the western diet could reduce the incidence of at least the first four conditions cited.

Comment: A great deal of time in the gastrointestinal clinic is involved with children with encopresis as a result of constipation. Although a fibre diet is inadequate to treat encopresis once it has been established, one could expect that widespread use of bran cereals and unrefined carbohydrate would lower the incidence of this annoying problem. In fact, in developing nations encopresis and chronic constipation almost do not exist.

(K. Nord, M.D.)

Rossi TM, et al: Extent and duration of small intestinal mucosal injury in intractable diarrhea of infancy. *Pediatr* 66:730, 1980

Eighty infants with intractable diarrhea of infancy were studied by small intestinal biopsy and treated with either elemental diet or parenteral nutrition. Mucosal injury was invariably found in all infants. Significant, persistent, mucosal injury existed for an average of six months in the majority of repeat biopsies. There was no mortality in the series. Twenty-two of the 28 infants in whom followup growth data were available excelled in weight and height velocity. The authors speculate that: (1) prolonged injury to the small intestinal mucosa is a common finding in many cases of intractable diarrhea in infancy; (2) elemental diets should be started early in the course of protracted diarrhea in young infants, and may need to be continued for several months since histologic and enzymatic changes of the small intestine may persist for extended periods; (3) Some infants will need parenteral nutrition.

Comment: This excellent study says it all. Please read it! (K. Nord, M.D.)

Ashkenazi A, et al: In vitro cell-mediated immunologic assay for cow's milk allergy. *Pediatr* 66:399, 1980

The production of leukocyte-migration-inhibition factor (LIF), by peripheral blood lymphocytes in response to an *in vitro* challenge with bovine B-lactoglobulin was assayed in 24 infants with cow's milk allergy, 24 normal controls, 18

*Abstracted from *Department of Pediatrics Newsletter*, CMDNJ, New Jersey Medical School, Newark—Vol. 3, No. 1 (January) 1981. Selections are made by Richard H. Rapkin, M.D., Professor of Pediatrics and Medical Director of Children's Hospital, Newark, who is editor; Franklin C. Behrle, M.D., Professor and Chairman of Pediatrics; and Shyan C. Sun, M.D., Associate Professor of Pediatrics and Director, Department of Neonatology, Children's Hospital, Newark, who are coeditors. Comments are prepared by them and their associates.

infants who had recovered from milk allergy, ten newborns, and ten infants suffering from acute gastroenteritis. A positive response was noted in all 24 infants with milk allergy which had been diagnosed clinically by recurrent symptoms after two successive challenges with cow's milk. No patient with gastroenteritis showed a positive result while two newborns and two controls showed LIF values approaching those in the milk allergy group. Patients with cow's milk allergy which dissipated over time so as to allow feedings of cow's milk showed progressive fall of LIF.

Comment: Previous attempts to define diagnostic markers for cow's milk allergy have had little success. Approaches using detection of circulating hemagglutinins and precipitins as well as specific IGE or IgA antibodies have not been reliable. Immediate hypersensitivity skin testings have not been useful. This study, however, appears to provide a very nice method of determining the presence of cow's milk allergy *in vitro*. There were no false-negatives and perhaps four false-positives in the study group.

If this technique proves to be reproducible, it will not only allow for positive diagnosis of cow's milk allergy but may provide information on when cow's milk safely can be reintroduced in the diet. The clinician then will be able to avoid a potentially dangerous clinical trial involving reexposure of antigens. Additionally, this technique offers the promise of allowing study of other potential food allergies. This is welcome as the issue of food allergy remains one of the most murky, confused, anecdotal and opinionated in medicine today.

(K. Nord, M.D.)

Giebink, GS, et al: Experimental otitis media (OM) after nasal inoculation of streptococcus pneumoniae and influenza A virus in chinchillas. *Infect Immunology* 30:445, 1980

Eighty-nine chinchillas were studied experimentally for pathogenesis of OM. Sixty-seven percent of a group developed OM when inoculated intranasally with pneumococcus followed by viral influenza A two days later. Only four percent of chinchillas inoculated intranasally with viral influenza A alone, 21 percent of chinchillas inoculated with pneumococcus alone, and none of those inoculated with normal saline developed OM.

Comment: This study resembles conditions accompanying OM in the human and suggests strongly that URIs contribute significantly in pathogenesis of OM. The chinchilla has been a useful animal for studying OM. This model will allow further data to be generated regarding OM.

(S. Khan, M.D.)

Pelton SI, et al: Disparate cultures of middle-ear fluids. *Am J Dis Child* 134:951, 1980

In children with bilateral otitis there is a disparity in culture results from tympanocentesis done on each ear.

Comment: No surprise. Obstruction of eustachian tube allows growth of organisms—why should they always be identical? In fact, careful review of the data in this paper shows that it is not unusual for there to be *H. influenzae* in one ear and *S. pneumoniae* in the other (4/221). In all other instances one ear is sterile while the other grows an organism or one ear has a pathogen while the other has a non-pathogen (? contaminant). The conclusion might be that when a pathogen is obtained from one tympanocentesis, it is most likely to be the etiologic agent for both otitis medias.

Steinhera PG, et al: Effect of lithium carbonate on leukopenia after chemotherapy. *J Pediatr* 36:923, 1980. **Lithium in hematology** (Editorial). *Lancet* 2:626, 1980

This brief review focuses on a well-documented side effect of lithium therapy, a neutrophil leukocytosis. Although lithium salts have been used for over 70 years in the treatment of psychiatric disorders, a peripheral leukocytosis was first noted only in 1950. Since then there have been several studies delineating the mechanism of lithium's action and practical application. Lithium enhances production of a humoral stimulator of granulopoiesis and also causes proliferation of pluripotential stem cells.

Although little improvement is obtained in the neutropenia of aplastic anemia, the drug is effective in Felty's syndrome. There has been a decrease noted in the incidence of fever and infection in neutropenic patients with lung carcinomas on chemotherapy. Toxicity is mild, mainly nausea and vomiting which may have been secondary to chemotherapy as well.

In a study evaluating lithium's efficacy in the pediatric age range, 37 patients with solid tumors (3 to 26 years) were randomly assigned to lithium treatment following courses of chemotherapy which resulted in leukopenia. The degree and length of neutropenia was significantly less in the lithium-treated group, as well as fewer signs of infection.

Comment: Unfortunately the problems with lithium include a narrow toxic/therapeutic ratio so that serum drug concentration must be measured. Lithium's side effect of nausea and vomiting can be a problem since many chemotherapeutic regimens share this complication. The recommendation is for larger studies to evaluate the efficacy in children on chemotherapy.

(B. Ryan, M.D.)

Rosa RM, et al: A study of induced hyponatremia in the prevention and treatment of sickle cell crisis. *N Engl J Med* 303:1138, 1980

The administration of DDAVP (a long-acting derivative of Vasopressin) intranasally and a high fluid intake resulted in a decrease in the frequency of sickle cell crisis in three young adults. It is known that one of the factors that enhances sickling is increased sickle-hemoglobin concentration. DDAVP, by lowering serum sodium and hence serum osmolality, should reduce sickle-hemoglobin concentration, thereby reducing sickling. The number and duration of crises were significantly reduced in these three patients. In addition, they all reported a decrease in pain in muscle, joints and abdomen. There were no untoward side effects except some muscle cramping when the serum sodium was reduced rapidly. Also anorexia and fatigue were reported at serum sodium below 120 mmol/l.

Comment: This is certainly an encouraging report. In the past many drugs were studied in the hope that through bonding of the agent to the sickle structure, polymerization would be inhibited. Delaying or slowing down polymerization to allow cells to pass through less than optimum environments seems a more simple and achievable approach. Therapy of crises using hypotonic solutions has been recommended in the past. The problem, however, of using fluids alone is that the effect is short-lived. This study needs to be reproduced with larger numbers. Also, as stated, children deserve special caution since hyponatremia may be more likely to lead to seizures.

(B. Ryan, M.D.)

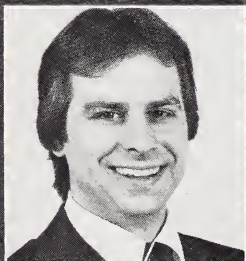
Bill Van Gieson has become real friendly with medical assistant Fallon.

Bill is part of our special Blue Shield professional relations staff. Bill and his colleagues specialize in answering physicians' questions, and training their medical assistants. You can depend on our professional relations staff for quick answers to your inquiries regarding claims, billing information, and contract interpretation.

In addition, professional relations staff members handle the enrollment of new participating physicians.

So, next time you run into a Blue Shield related problem, call on us for the answer.

Be sure and visit our Blue Shield display booth (#33) at the spring meeting of the Medical Society of New Jersey - May 16-18th at the Meadowlands Hilton.



*It's our job to
make things simple.*



Blue Shield of New Jersey



DOCTORS' NOTEBOOK

Trustees' Minutes March 15, 1981

A regular meeting of the Board of Trustees was held on Sunday, March 15, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

County Representation at Board Meetings . . . Noted that a communication to county society presidents for designation of an official representative from among its delegates to attend meetings of the Board of Trustees (mandated by resolution to the 1980 House of Delegates) elicited one reply—Camden County—but that attendance of county society presidents at the Board meetings was good. However, all counties are to designate an official representative from their respective county delegations.

Membership . . . Noted that paid membership through February 28, 1981 was 5,544. About 100 have been added since that date.

. . . Concluded that a recruitment campaign from the State Society offices did not appear to be practical at this time. Individual hospitals where new physicians apply for credentials and staff privileges seem to be the most favorable recruitment source.

Note: Differing opinions as to the number of physician providers in New Jersey as reported by the AMA, the State Board of Medical Examiners, Blue Shield and Prudential Insurance Company demonstrate the reason for the difficulty in arriving at an actual physician supply; however, the use of the number of physicians covered by professional liability insurance in New Jersey as a basis for determining the figure indicates 9200 to 9600 practicing physicians.

CME Requirements . . . Noted that, of the previously reported 130 memberships terminated for failure to comply

with CME requirements, 78 have been reinstated and it is anticipated that the total loss of membership may be no more than 40.

Membership Inquiry and Complaint Committees . . . Approved a recommendation that the Board recommend to the House of Delegates that the four Membership Inquiry and Complaint Committees be discharged, and their duties be assumed by the Negotiating Committee.

MSNJ Charter Revision . . . Noted that Senate Bill 1390 to permit MSNJ charter change has passed both the Senate and the Assembly and it is expected that the Governor will sign it before April 15. The House of Delegates, therefore, may be in a position to take positive action at the Annual Meeting in May on medical student and specialty society representation in the House.

State Board of Medical Examiners vs. Driggs . . . Noted that there has been no change in the status of this litigation since the report that it is being scheduled for a new hearing.

Radiological Regulations . . . Noted that the opinion of the Appellate Court was in favor of the State Board of Medical Examiners' ruling on the provision of mandatory radiological services to chiropractors.

Excessive Fee Regulation . . . Noted that the response to a proposed regulation of the State Board of Medical Examiners on excessive fees for professional services indicated that the Society shares the concern of the State Board in the matter of excessive fees; however, it was pointed out that the proposal may destroy completely the judicial mechanism of the Society which addresses between 300 to 500 fee questions in a given year. The value of the judicial mechanism was explained in the hope that the State Board would consider using it for questions related to fee charges of the membership of the Medical Society of New

Jersey. Reference was made to the section in the State Board proposal relating to fee discussions prior to rendering services, and clarification was requested. The State Board was urged to consider flexibility and practicality on this point.

. . . Noted that the Executive Secretary of the State Board of Medical Examiners advised that the comments of the Society were indexed into the State Board's file until such time as a ruling on the proposal is made.

IRS Determination on Subordinated Loan Payments . . . Noted that the District Director (Newark) has requested a new technical advice determination from Washington concerning the IRS position on subordinated loan payments, and the matter may be completed favorably within several months.

Professional Liability Insurance Rates . . . Noted that no determination had been made by the Department of Insurance concerning the MIE of New Jersey's request for a rate increase of 9.7 percent or the 28 percent rate increase requested by the Reinsurance Authority. The filing of the carrier for the New Jersey Hospital Association, Health Care Insurance Exchange, to write claims-made insurance for physicians in New Jersey has been approved.

College of Medicine and Dentistry of New Jersey . . . Received a report from the President of CMDNJ which noted:

1. That the budget for fiscal year 1981-1982 is austere, and it is felt that more cuts may be made by the Legislature.
2. That the State Department of Human Services received a Certificate of Need to assume operational responsibility for Raritan Valley Hospital to house mildly retarded adults.
3. That the President of the College addressed the State Legislature on February 19 in commemoration of CMDNJ's tenth anniversary (see April issue (78:315-316)).
4. That CMDNJ purchased (for \$1)

Pulaski Park in Camden across the street from the Cooper Medical Center and the site of the future VA geriatric hospital.

5. Approved architects' designs for the clinical/educational building for the faculties of CMDNJ-New Jersey School of Osteopathic Medicine and CMDNJ-Rutgers Medical School at Camden and for additions at the Piscataway campus.

6. That the American Osteopathic Association had approved full accreditation to the CMDNJ-New Jersey School of Osteopathic Medicine.

7. That the CMDNJ Board of Trustees has approved a new non-tenure track for full-time faculty desirous of spending all their time in teaching and patient care, to help CMDNJ meet the need for a strongly clinical-oriented faculty.

8. That the National Endowment for the Humanities awarded \$146,000 to CMDNJ to support its teaching in biomedical ethics and other health-care humanities.

9. That College Hospital has observed that the number of indigent patients increased by two percent each month (December through February) and this could bring up another question as to the effectiveness of the DRG program.

10. That the State Government is applying pressure on the College to have the medical schools take over and provide professional services at state mental institutions. There is a need for better coordination of MSNJ's Council on Mental Health and the Department of Psychiatry at the College.

11. That the College is contemplating entry into the nursing field, probably in a diploma-type, associate-degree program.

New Jersey Hospital Association . . . Referred a position paper on no-code orders from the Hospital Association (currently being revised by that body) to the Council on Medical Services for study and report.

Perinatal Designations . . . Noted that none of the existing perinatal centers will be closed. Level III tertiary care facilities are designated as: Saint Peter's Medical Center, New Brunswick; Newark Beth Israel Medical Center; Saint Joseph's Hospital and Medical Center, Paterson. Two combined facilities are Monmouth Medical Center, Long Branch/Jersey Shore Medical Center, Neptune and Our Lady of Lourdes Hospital, Camden/Cooper Medical Center, Camden. Health Research and Education Trust (HRET) of New Jersey will make a one and a half to two-year study to de-

termine if the hospitals meet required criteria. Hospitals in Levels I and II will be included in the rate structure on the basis of services offered.

Council on Medical Services . . . Voted to approve the following recommendations of the Council on Medical Services which resulted from the referral of Resolution #5 (1980 House of Delegates) opposing the continuing authority of the Health Systems Agencies (HSAs). The Council noted that HSAs are not cost effective and tend to be arbitrary in granting or denying expansion of health services.

(1) That MSNJ exert its influence via the AMA toward the ultimate repeal of Public Law 93-641 (National Health Planning and Resources Development Act).

(2) That MSNJ seek to modify the functioning of HSA's in New Jersey so as to increase the capacity for local decision making, while reducing the power of the State and Federal Government to reverse or obstruct such decisions.

Note: Recommendations 1 and 2 currently are supported by the AMA and therefore do not require further discussion.

(3) That MSNJ seek to enhance the involvement of its members in health planning.

(4) That these recommendations be offered to the House of Delegates in 1981 in the form of a resolution from the Board of Trustees that might be conveyed to the AMA House of Delegates for their vote as well.

Note: This is in compliance with the mandate of the 1980 House of Delegates.

Council on Public Relations

1. Golden Merit Award Ceremony . . . Noted that the Golden Merit Award Ceremony will be held at 12 noon on Saturday, May 16 during the Annual Meeting in Secaucus.

Note: The Council regrets the change in location from the Society's headquarters in Lawrenceville where the ceremony has been held for two years. Comments had been very favorable, attendance was good, the recipients received special attention, and a luncheon was provided for their guests.

2. Expose Cost of Governmental Regulations . . . Noted that directive to the Council to disclose to the public the high cost and adverse effect resulting from governmental regulations has been ac-

complished through releases to the news media.

3. DRG Program . . . Noted that the Council's news releases concerning the DRG concept, with particular emphasis on the principle that MSNJ's first priority for hospitalized patients in quality medical care, have shown good results.

4. Continuing Projects . . . Approved the Council's continuing projects for 1980-1981:

- a. Newsletter
- b. News releases
- c. Golden Merit Award Ceremony
- d. Annual Meeting press releases
- e. Orientation programs for new members
- f. Voluntary blood donations
- g. Radio broadcasts under the auspices of county medical societies
- h. TV programs
- i. Diabetes Detection Week
- j. Placement Service
- k. Drug abuse education

Council on Public Health . . . Approved the following recommendations from the Council in Public Health:

(1) That the Medical Society of New Jersey request the New Jersey Department of Health to reconsider N.J.A.C. 8:31-26.3, the regulation which mandates rubella serological testing and immunization of all hospital personnel.

(2) That the 1981 Eye Health Screening Program be conducted during the week of September 21, 1981.

Medical Defense and Insurance . . . Approved the following recommendation:

That the Medical Society of New Jersey offer to the membership the Retired Lives Reserve Program, as presented by Professional Corporations Limited.

Note: See page 346 this issue.

Retirement Plan for Physicians . . . Approved the following recommendation from the Committee on Retirement Plan for Physicians:

That the Medical Society of New Jersey offer the financial planning proposal, as presented by PRO Services, Inc., to the membership.

Medical Aspects of School Sports . . . Approved the following recommendation from the Committee on the Medical Aspects of School Sports:

That the Medical Society of New Jersey adopt the Pre-Participation Physical Evaluation Guidelines and submit them to the State Board of Education for implementation.

Assembly Bill 2135 . . . Agreed to rescind its previous action concerning Assembly Bill 2135, which provides that an optometrist who discovers any non-refractive eye disease or disorder must advise the patient in writing to seek medical attention, and voted **approval**.

Note: Previously the Board had given conditional approval pending deletion of the words "in writing."

Assembly Bill 3002 . . . Voted to oppose actively Assembly Joint Resolution 3002 which would create an eleven-member commission (none of whom is a physician) to study the role of the clinical specialist/nurse practitioner in the provision of health care. It was noted that the State Board of Medical Examiners recently had voted to oppose creation of the commission since there never has been a demonstrated need for the clinical specialist/nurse practitioner who is illegal in this State.

New Jersey Graduate Medical Education Program . . . Approved the following recommendation:

That the recommendation of the Board of Higher Education for an increase in the Governor's 1982 budget appropriation for the state Graduate Medical Education program be referred to the Committee on Medical Education for study.

Note: Since 1979 the Graduate Medical Education program has provided seed money to support the development of eight primary care residency programs. At the end of the three-year funding period these programs will be fully developed and will train 141 primary care physicians each year.

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

The following report was prepared by our Committee on Aging, under the chairmanship of Dr. Abraham S. Lenzer, with the assistance of Drs. Charles L. Cuniff and John Winslow. The original impetus was provided by Dr. William A. Dwyer, Jr., and resulted from the problem of locating long-term care for many patients in general hospitals. The report is an example of the Foundation's interest in the overall care of this large and growing segment of our population. This concern goes beyond

utilization. The report, titled: "An Overview: Health Care and Long-Term Services for the Aging," speaks for itself.

"There is a growing public awareness of the multiple problems of large segments of our aging population. Retirement, loss of spouse, illness, disabilities and economic strictures often combine to overwhelm the physical and emotional resources of the aging person and his family. While a number of social and medical efforts have been made to alleviate these problems, there is an urgent need to develop broader and integrated systems which are more responsive to the social, economic and health needs of our older citizens.

"Perhaps the overutilization of acute care hospital beds and the resulting consequences of highly increased costs for medical care, as much as anything, have focused attention on the need for alternate facilities. It has been estimated that on any given day, in New Jersey, there are more than one thousand (1,000) elderly patients in our general hospitals who are there simply because there is now here else for them to go. This situation is indicative of our failure to confront the underlying needs of the aging.

"The New Jersey Foundation for Health Care Evaluation views these issues as a problem of epidemic proportions. Historically, the medical profession, through the State and County Medical Societies, has been responsive to major public health problems. The unsolved health problems of the frail, elderly present a major new challenge for organized medicine. What is needed is to devise, develop and implement community and county-wide health care approaches that can eliminate or drastically reduce the costly, ineffective and fragmented conditions that exist today.

"The Foundation urges the development, in each county, of health care systems that:

1. Address preventive aspects of senior health care with counseling, health screening, nutrition programs and other such supportive measures;
2. Address the mental and physical problems that compound the difficulties of daily living for the elderly;
3. Recognize the need for protective care, on multiple levels for some aging persons;
4. Respond to the need for humane care for the terminally ill;
5. Relate to Community and Government plans for the social, environmental and economic needs of the aging.

"It is inevitable, and perhaps fortunate, that different communities and counties will have a different organization or resources for the aged. It would be helpful if each county medical society would devise a patient-oriented system which can be integrated with the agencies and facilities for the aging within the county. For example, with federal funding, the New Jersey Department of Human Services presently is developing as a pilot experiment in Middlesex County, the National Long-Term Care, 'Channeling,' *Demonstration Program*. The Foundation has been in communication with some of the principles of this Middlesex program and they have welcomed the interest of the Medical Society. One letter from them states, 'Without question, the input of physicians is critical to planning care for the disabled and frail elderly. Be assured that the medical profession will be well represented on the New Jersey Long-Term Care Planning Group currently being constituted.'

"The ultimate purpose of our proposed medical care system would be to maintain each older person at an optimal functioning level in his own community. Our aim is for decency and humanity consistent with the American character. In the event of a new sickness or disability, the effort would be to return the individual to the previous status if at all practicable. Where this might prove impossible, then alternate placement at the proper level would be sought. Review systems such as PSRO could be adopted to ensure standards for optimal utilization in a wide range of levels of care, from home care, which would be preferred, on up through skilled nursing facilities and acute care hospitals.

"The county medical societies should work with other interested local groups to:

- "1. Insure ready access to medical care for all senior citizens;
- "2. Provide medical screening programs by physicians, (M.D. and D.O.) as well as dentists, on a voluntary or contractual basis;
- "3. Provide for referral with free choice of physicians and hospitals whenever possible;
- "4. Provide choice of primary physician, when at all possible, to insure channeling and continuity of care;
- "5. Integrate medical services with the effective community agencies, including senior citizens, VNA and programs established by local or federal government; (a program such as that being organized in Middlesex County

will have a case manager who would be of extreme value in aiding these goals;

"6. Encourage active participation by physicians in an advisory capacity in community and governmental programs;

"7. Expand the medical role in home-care programs as well as in alternate residential or long-term care facilities;

"8. Utilize PSRO to assure accountability and quality of medical services at all levels, including home care.

Clearly, joint efforts such as these for our senior citizens would do much to reduce the universal fear of aging with its disabilities, impoverishment and loneliness. Coordination of services towards better health care along with developing mechanisms for better social and economic protection would do much to improve the quality of life for older persons. Prevention of illness, along with attempts to eliminate some of the social causes of illness are always cost effective. The aim would be to provide ready access to medical services, preferably through a primary physician who would provide continuity of care, thus avoiding expensive fragmentation and duplication, while promoting health for each person."

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

The College's commencement exercises, scheduled for the morning of May 29 at the Garden State Arts Center, Holmdel, promise to be a memorable event for CMDNJ and for the State of New Jersey. As an appropriate climax to the year-long celebration of the tenth anniversary of CMDNJ, the presentation of the first medal ever awarded by the College will be made during the exercises.

William T. Cahill, who served as Governor of New Jersey when CMDNJ was created in 1970, has been named recipient of the medal, following unanimous approval by the CMDNJ Board of Trustees in February. The medal will commemorate the ten years of the College and at the same time will take note of Governor Cahill's most significant contribution in its formation and in the successful passage of its enabling legislation.

A record number of students—nearly 500—will receive degrees and certificates. With the first graduating

class of the CMDNJ-New Jersey School of Osteopathic Medicine participating, all six schools of CMDNJ will be represented. This will be the largest graduating class (493) in the College's young history. Among them will be 230 new M.D.'s—137 from the CMDNJ-New Jersey Medical School and 93 from the CMDNJ-Rutgers Medical School. In addition, 24 graduates from the CMDNJ-New Jersey School of Osteopathic Medicine will receive the first D.O. degrees ever awarded in the State, bringing the total number of new physicians to 254.

Representing the College's three other schools, 75 graduates will receive the D.M.D. degree from the CMDNJ-New Jersey Dental School, 15 will receive the Ph.D. degree from the CMDNJ-Graduate School of Biomedical Sciences, and 149 will receive certificates from the CMDNJ-School of Allied Health Professions.

The graduates and their families and guests, as well as members of the faculty, CMDNJ Board of Trustees, State officials and other guests, will hear an address by June Jackson Christmas, M.D., medical professor and director of the program in behavioral science at the School of Biomedical Education, City College, CUNY.

Dr. Christmas is noted for establishing and directing the Harlem Rehabilitation Center, which pioneered in the development of social-psychiatric, community-based services. The Center gained national reputation for its innovation in hiring and training unemployed and underemployed community residents as mental health workers.

From 1972 to 1980 Dr. Christmas served as commissioner of Mental Health, Mental Retardation and Alcoholism Services for the City of New York. She served as president of the American Public Health Association and as vice-president of the American Psychiatric Association. Dr. Christmas headed the Carter/Mondale Transition Planning Group developing policy options and initiative for the Department of Health Education and Welfare, and was the executive coordinator of the Task Panel on Community Support Systems of the President's Commission on Mental Health.

Those who will receive honorary degrees are:

William O. Baker, Ph.D., chairman of the board, Bell Laboratories, and member of the New Jersey Board of Higher Education, who has received worldwide

recognition as a scientist investigator;

Daniel J. Callahan, Ph.D., founder and director of the Institute of Society Ethics and the Life Sciences, Hastings-on-Hudson, N.Y., a widely known and respected scholar in the field of bioethics;

Irwin D. Mandel, D.D.S., professor of dentistry at Columbia University, a renowned researcher in the field of periodontal diseases and internationally recognized saliva specialist, who has served as research consultant to CMDNJ-New Jersey Dental School;

Darrel J. Mase, Ph.D., professor emeritus, University of Florida, who worked his way up to the top of the field as an eminent speech pathologist and well respected allied health science theoretician;

Frank Henry Netter, M.D., a foremost medical illustrator and artist, whose work has had an impact on generations of medical students throughout the world; and

Hans Popper, M.D., Ph.D., former dean and president, Mt. Sinai School of Medicine, who is an internationally known scientist and medical administrator as well as a renowned liver pathologist.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Won S. Cho, M.D., 1303 Midmeadow Road, Towson, MD 21204. Korea University, 1963. Board eligible. Group, partnership, or solo. Available on one month's notice.

CARDIOLOGY—Lawrence J. Gessman, M.D., 21 Sabine Avenue, Narberth, PA 19072. University of Pennsylvania 1974. Board certified. Group, partnership (preferably with cardiac catheterization). Available.

G. R. Kolluru, M.D., 914 South Avenue, Apt. E-33, Secane, PA 19018. Andhra (India) 1973. Board certified (IM). Group, partnership, solo. Available July 1981.

FAMILY MEDICINE—Robin O. Winter, M.D., Hunterdon Medical Center, Flemington, NJ 08822. Einstein 1978. Board eligible. Group, partnership, solo. Available August/September 1981.

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule contains:

Pentylentetrazole 100 mg
 Nicotinic Acid 100 mg
 Ascorbic Acid 100 mg
 Thiamine HCL 25 mg
 L-Glutamic Acid 50 mg
 Niacinamide 5 mg
 Riboflavin 2 mg
 Pyridoxine HCL 3 mg
AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



GASTROENTEROLOGY—George J. Rezk, M.D., 7713 Fort Hamilton Parkway, Brooklyn, NY 11228. Bologna (Italy) 1976. Board eligible. Group or partnership. Available July 1981.

GENERAL PRACTICE—Kirit J. Shah, M.D., 136 Thornhill Road, Cherry Hill, NJ 08003. S.S. Medical (India) 1970. Group or solo in community in need of a physician. Available.

HEMATOLOGY/ONCOLOGY—Frank Gentile, M.D., 654 Dahill Road, Brooklyn, NY 11218. Bologna (Italy) 1972. Board eligible. Solo, group, associate, partner. Available July 1981.

INTERNAL MEDICINE—Modhi Gude, M.D., 210 Shippen Street, Weehawken, NJ 07087. Andhra Medical (India) 1968. Subspecialty endocrinology. Board certified. Group, partnership, or solo. Available July 1981.

Maria Del Rosario Gomez, M.D., 294 Thunder Circle, Bensalem, PA 19020. Madrid 1976. Board eligible. Group or partnership. Available July 1981.

William C. Zuck, Jr., M.D., 1769 Raleigh Court West, Apt. 25-B, Ocean, NJ 07712. Graz (Austria) 1977. Board eligible. Solo or group. Available July 1981.

Sanford L. Taffet, M.D., 160 East Hartsdale Avenue, Hartsdale, NY 10530. NYU 1976. Subspecialty, gastroenterology. Board certified. Partnership or group. Available July 1981.

Arvind M. Mehta M.D., #1-F, Bldg. I, 40 Prospect Avenue, Norwalk, CT 06850. M.S. University (India) 1975. Subspecialty, cardiology. Board eligible. Group, partnership or multi-specialty group. Available July 1981.

John Aylward, M.D., 86 East Almira Street, Bloomfield, NJ 07003. CMDNJ 1978. Group or partnership. Available July 1981.

Vijay K. Nellore, M.D., 134 North Street, Bayonne, NJ 07002. Osmania (India) 1973. Solo, group, or institutional. Available July 1981.

Mark Isserman, M.D., 103 Dennis Avenue, Port Allegany, PA 16743. Jefferson 1977. Board certified. Solo, partnership, group. Available July 1981.

Prabhakar N. Vaidya, M.D., 7752 Montgomery Road, Apt. 81, Cincinnati, OH 45236. Seth G.S. Medical College (India) 1969. Board certified. Single or multi-specialty group, partnership, or hospital-based. Available.

Lakhu Janimal, Rohra, M.D., 86-19 Elmhurst Avenue, Apt. 3-E, Elmhurst, New York 11373. Baroda (India). Board eligible. Solo, associate, group. Available July 1981.

M. A. Menon, M.D., 355 Crale Boulevard, #202, Melvindale, MI 48122. Armed Forces Medical College (India) 1974. Subspecialty, gastroenterology. Board certified. Group, solo. Available July 1981.

Bankim D. Shah, M.D., 100 Hospital Plaza, #705, Paterson, NJ 07503. T.N. Medical (India) 1974. Group, partnership, solo. Available July 1981.

NEPHROLOGY—Krishnababu Chunduri,

M.D., 2121 Shore Parkway, Apt. 2-F, Brooklyn, NY 11214. Guntur (India) 1973. Board eligible. Solo or group. Available.

Vijay K. Nellore, M.D., 134 North Street, Bayonne, NJ 07002. Osmania (India) 1973. Solo, group, or institutional. Available July 1981.

NUCLEAR MEDICINE—M. I. Straub, M.D., 254 Frances Street, Teaneck, NJ 07666. Semmelweis (Hungary). Special interest, diagnostic radiology. Board eligible. Available July 1981.

OBSTETRICS/GYNECOLOGY—Kailash R. Makhija, M.D., 5628 Fifth Avenue, Apt. B-10, Pittsburgh, PA 15232. GMC (Bombay, India) 1974. Board eligible. Group, partnership, solo, with coverage, suburban area. Available July 1981.

F. Adibi, M.D., 84 Skyline Drive, Chalfont, PA 18914. Tehran (Iran) 1967. Board certified. Group/partnership. Available.

Dilipkumar G. Patel, M.D., 72 Duke Street, New Brunswick, NJ 08901. Baroda (India) 1974. Board eligible. Group, associate, solo, hospital. Available July 1981.

Mohammed M. Mohiuddin, M.D., 215 Locksley Road, Syracuse, NY 13224. Osmania (India) 1973. Board eligible. Any type practice except academic position. Available July 1981.

Mridu B. Agarwal, M.D., 318 East 15th Street, Apt. 6-A, New York, NY 10003. Lady Hardinge (India) 1971. Solo, group, or partnership. Available July 1981.

Jung Fu Chen, M.D., P.O. Box 218, Petersburg, WV 26847. National Taiwan University 1956. Board eligible. Partnership, solo. Available.

OCCUPATIONAL MEDICINE—Louis Z. Fauteux, Jr., M.D., 294 Carlton Avenue, Piscataway, NJ 08854. Georgetown 1947. Board certified (IM). Board eligible (OM). Industrial. Available.

PATHOLOGY—Sitamahalakshmi Nutakki, M.D., 22 Metropolitan Oval, #5G, Bronx, NY 10462. Guntur (India) 1970. Board eligible. Group or partnership. Available.

Meera V. Bodas, M.D., 4 Manitou Way, Scotch Plains, NJ 07076. Nagpur Medical (India) 1967. Board eligible (AP/CP). Group (part-time also acceptable). Available July 1981.

Shokat Fattgh, M.D., 260 First Street, Mineola, NY 11501. Baroda (India) 1975. Board certified. Any type practice. Available.

Alexander J. Aplasia, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified (AP and CP). Any type practice including institutional. Available June 1981.

Aruna Kumar, M.D., 6223-B Newport Avenue, Norfolk, VA 23505. J.L.N. Medical (India) 1972. Board eligible (AP/CP). Group, solo, or partnership. Available July 1981.

PEDIATRICS—Anil G. Pradhan, M.D., 118 Grove Park, Fort Dix, NJ 08640. Bombay (India) 1972. Board certified. Solo, partnership, associate, group. Available.

Rajendra C. Parikh, M.D., 77-07 Woodside Avenue, Apt. 3-A, Elmhurst, NY

A peripheral vasodilator

for treatment of
**leg cramps
cold feet
tinnitus
discomfort on
standing**

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	.....	300 mg.
Ascorbic Acid	.....	150 mg.
Thiamine HCL (B-1)	.....	25 mg.
Riboflavin (B-2)	.....	2 mg.
Pyridoxine HCL (B-6)	.....	10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	.....	250 mg.
Niacinamide	.....	75 mg.
Ascorbic Acid	.....	150 mg.
Thiamine HCL (B-1)	.....	25 mg.
Riboflavin (B-2)	.....	2 mg.
Pyridoxine HCL (B-6)	.....	10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	.....	100 mg.
Niacinamide	.....	75 mg.
Ascorbic Acid	.....	150 mg.
Thiamine HCL (B-1)	.....	25 mg.
Riboflavin (B-2)	.....	2 mg.
Pyridoxine HCL (B-6)	.....	10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



11373. Baroda (India) 1975. Board eligible. Group, partnership, solo, or institutional. Available June 1981.

Shara J. Doshi, M.D., 304 Fir Street, Raceland, Louisiana 70394. B.J. Medical (India) 1969. Board eligible. Solo, group, partnership, clinic. Available.

Fe C. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified. Any type practice. Available June 1981.

Yogesh J. Pandya, M.D., 24 Paerdegas—15th Street, Brooklyn, NY 11236. Baroda (India) 1973. Board eligible. Solo, group, partnership, hospital-based. Available.

Susheela Raghunathan, M.D., 9 Weston Place, East Brunswick, NJ 08816. India 1973. Board eligible. Group, institutional, clinic, emergency room, or house staff, student health center. Available July 1981.

PSYCHIATRY—Florence Ouseph, M.D., 2200 South Rock Road, Apt. 1108, Wichita, Kansas 67207. Christian Medical (Vellore, India) 1975. Board eligible. Institution (VA Medical Center). Available November 1981.

RADIOLOGY—U. Chaibongsai, M.D., 992 Woodmere Drive, Westfield, NJ 07090. Siriraj (Thailand) 1968. Board certified. Part-time, group, partnership. Available.

Indu M. Solanki, M.D., 266 Beaufort Avenue, Livingston, NJ 07039. B.J. Medical (India) 1967. Board certified. Solo, group, or partnership. Available.

Sita V. Krishnaswamy, M.D., 1735 Haight Avenue, Bronx, NY 10461. Grant Medical College (India) 1972. Emphasis on therapeutic radiology. Board eligible. Any type independent practice or partnership. Available July 1981.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379. Shah (India) 1969. General practice and rehabilitation medicine. Available on three months' notice.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available July 1981.

Thomas A. Giangrasso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available July 1981.

SURGERY, GENERAL—Mohammad Qubair, M.D., 2694 South Hoyt Street, Lakewood, CO 80227. Pakistan 1970. Board eligible. Partnership, solo. Available July 1981.

Jin-Young Lee, M.D., St. Mary's Hospital, 56 Franklin Street, Waterbury, CT 06702. Seoul National (Korea) 1971. Board eligible. Group, partnership, solo. Available July 1981.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available July 1981.

S. R. Bajina, M.D., E1501, Park Towne Place, 2200 Benjamin Franklin Parkway, Philadelphia, PA 19130. Special interest—gastrointestinal endoscopy. Board certified. Group, group, institutional-based. Available.

Rajendra M. Agarwal, M.D., 318 East 15th Street, New York, NY 10003. King George's (India) 1968. Solo, group, or partnership. Available July 1981.

P. Joshua Mammen, M.D., 404 West 51st Street, Apt. 2-B, New York, NY 10019. Trivandrum (India) 1970. Board eligible. Group, partnership, solo. Available July 1981.

B. Paulauskas, M.D., Route 1, Box 273-M, Lake Placid, FL 33852. Lithuania 1972. Special interest, vascular surgery. Board eligible. Group, partnership, solo. Available.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available July 1981.

Inder J. Singh, M.D., WCMC #1-C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available July 1981.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available July 1981.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available June 1981.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available July 1981.

UROLOGY—Elliott Lieberman, M.D., 16-66 Bell Boulevard, Apt. 730, Bayside, NY 11360. SUNY-Downstate 1976. Group or partnership. Available July 1981.

William Kohlberg, M.D., 3450-17A Wayne Avenue, Bronx, NY 10467. Pittsburgh 1975. Board eligible. Group or partnership. Available July 1981.

Paul A. Church, M.D., 435 East 70th Street, Apt. 27-C, New York, NY 10021. Cornell 1975. Board eligible. Solo, partnership, group. Available June 1981.

Vasant Betkerur, M.D., 10015 South Hill Terrace, 28/202, Palos Hill, IL 60465. Government Medical (India) 1973. Solo, partnership, group. Available July 1981.

Harvey Schoenbrum, M.D., 1249 Park Avenue, Apt. 14-A, New York, NY 10029. Pittsburgh 1976. Board eligible. Group, partnership. Available July 1981.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available June 1981.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available July 1981.

Robert D. Zimmerman, M.D., 206 Friar Lane, Clifton, NJ 07013. Chicago Rush-Presbyterian. Board eligible. Partnership, solo, group. Available July 1981.

Talluri Balaji, M.D., 1926 West Harrison St., Apt. 916, Chicago, IL 60612. Osmania (India) 1973. Solo. Available July 1982.

LETTERS TO THE JOURNAL

HMO

February 24, 1981

Dear Dr. Krosnick,

Polemics and personal attacks during discussions of great public importance serve no useful purpose. However, since you chose to print Dr. Primich's personal attack on me, rather than on the subject of debate, I feel forced to reply.

Let me assure Dr. Primich that I am not "impaired" by reason of a "bleeding heart" or hardening of the "issues" or "tissues."

May I remind Dr. Primich that Webster defines subsidy as "aid; assistance; any gift of money or property made by one person to another by way of financial aid." Therefore, I feel that I have used the word correctly in my statements. Copayments, reductions in fees, and so on are subsidies by definition.

This, then, is the real issue that needs our attention: Will the HMO do a better job of stimulating competition, or not? In the end, competition is the essence of our system. Further, for proper discussion we also must carefully divide HMOs into the staff, group, and individual practice association types, since each one represents a different type of fair and unfair competition.

However, I am sure to Dr. Primich's

delight, our present elected officials have made the question moot for the moment by phasing out all of these Federal subsidies. The people have spoken and we will now be able to observe the results—in time.

Let us always remember what Thomas Huxley said so well—"If all think alike, no one is thinking very much."

(signed) Arthur Bernstein, M.D.

Colombia Discovered

March 4, 1981

Dear Editor:

A few years ago, when we moved to Costa Rica (bag, baggage, pets, grandmother, teenagers and all), I promised to write you about our adventures. But I have been so busy living, I haven't had time!

However, today, while listening to the news—gloom, unemployment, energy crises, wars—it occurred to me your readers might enjoy the "Saga of the Birds." So, here I am, pen in hand.

Just like Columbus, we have "discovered" South America. We are now in Colombia (a democratic republic, known for its respect of human rights) where, for the first time in many years,

we can walk the streets with little fear, while enjoying a cost of living among the lowest in this hemisphere.

It all began when we found a lovely, old coconut plantation on the Caribbean Sea. And, to complete its unique setting, when we looked away from the sea we saw, towering over everything, 19,000 feet high and snow-capped the year 'round, majestic Mount Columbus. We knew instantly we were home!

It may be hard to believe—hundreds of waving, green palms, blue sky and sea, pounding surf, golden sand, snow-capped (and skiable) peaks—but it is all here, on the Pan-American Highway near Santa Marta, the oldest (456 years) city in all of the Americas.

So, we have a new love: our beach and home in Colombia. We feel we have found something excitingly different and, being human, we have to share it. (We are in retirement, have dared to dream, and are making it come true. Sometimes difficult but never boring!) You may, if you wish, write us by international air mail (35¢ per half-ounce) at P.O. Box 5222, Santa Marta, Colombia. It may take a little while, but we promise to answer each and every letter.

Now, from beautiful Santa Marta, we wish you salud (health), dinero (wealth) and much amor (love)!

(signed) Juanita Bird (Mrs. Lewis)

LETTERS FOR THE INFORMATION OF OUR READERS

DMSO Controversy

January 23, 1981

Dear Congressman Roe:

Your article in the New Jersey Medical Society Journal of January 1981 (*J Med Soc NJ* 78:54-55) about DMSO is of interest to all physicians. Your efforts to get definitive tests on its long-term toxicity and production of opacities in the lens is laudable. I have used it in very short-term treatment of arthritis pain with excellent results but will not prescribe it again until the possible toxic effects, including vision are resolved.

You probably already have seen FDA Drug Bulletin V. 10, No. 3, November 1980 which includes a summary on DMSO and the absence of well-controlled toxicity studies in man.

With appreciation for your interest, support and encouragement of additional research on this matter.

(signed) Lewis L. Coriell, M.D.

Director, Institute for Medical Research

February 24, 1981

Dear Doctor Coriell:

Just a note to let you know that I have received your recent communique commenting on my recent article in the New Jersey Medical Society Journal (*J Med Soc NJ* 78:54-55, (Jan) 1981) on the DMSO controversy and I am most pleased to have your medical observations confirming the critically important need for an objective evaluation on this pain-relieving drug so that the value of DMSO for the physician's use in the treatment of patients can be established, once and for all.

Both the House Select Committee on Aging and the Senate Committee on Labor and Human Resources last year

conducted hearings on DMSO. Doctors, researchers and DMSO users appeared before these panels enthusiastically describing DMSO's effectiveness in reducing the pain, inflammation and stiffness associated with arthritis, bursitis, tendonitis and scleroderma. Despite DMSO's potential, however, the drug is still unavailable to millions of Americans who suffer chronic pain. The Food and Drug Administration is adamant in its refusal to approve DMSO because it claims to have insufficient scientific data.

Unfortunately, there are presently no ongoing studies to establish the effectiveness of DMSO in the treatment of arthritis—a situation totally unacceptable to the 31 million Americans who suffer from this crippling disease. Consequently, thousands of sufferers each year go abroad for DMSO treatments or pay exorbitant prices for bootleg versions of the drug here in the United States. Millions more cannot afford the relief they seek.

For your information and guidance I am enclosing a copy of my Bill No. H.R. 1718 [see below] that I have joined in sponsoring calling for a clinical study of the safety and effectiveness of DMSO for use by patients with arthritis to be conducted by the National Institute for Arthritis, Metabolism and Digestive Diseases. By taking this step we may be able to make a low-cost, effective pain reliever available to millions who suffer chronic pain.

Greatly appreciate your letter.

Be assured of my continued fullest efforts in every respect.

With all good wishes.

(signed) Robert A. Roe
Member of Congress

97th Congress
1st Session

H.R. 1718

To direct that a clinical investigation of the safety and efficacy of dimethyl sulfoxide as a drug to be used by persons with arthritis be conducted through the National Institute of Arthritis, Metabolism, and Digestive Diseases.

In The House of Representatives
February 5, 1981

Mr. Hopkins (for himself, Mr. Anderson, Mr. Annunzio, Mr. AuCoin, Mr. Bedell, Mr. Beville, Mr. Broyhill, Mr. Corcoran, Mr. Downey, Mr. Findley, Mr. Frank, Mr. Frost, Mr. Gibbons, Mr. Glickman, Mr. Goldwater, Mr. Gore, Mr. Grisham, Mr. Guyer, Mr. Hinson, Mr. Hollenbeck, Mr. Howard, Mr. Hughes, Mr. Kogovsek, Mr. Lagomarsino, Mr. Livingston, Mr. Lott, Mr. Madigan, Mr. Mavroules, Mr. Mazzoli, Mr. Mineta, Mr. Minish, Mr. Molloy, Mr. Mottl, Mr. Neal, Mr. Oberstar, Mr. Panetta, Mr. Pepper, Mr. Pickle, Mr. Roe, Mr. Russo, Mr. Shumway, Mr. Snyder, Mr. Solomon, Mr. Stark, Mr. Stump, Mr. Vento, Mr. Whitehurst, Mr. Whitley, Mr. Whittaker, Mr. Winn, Mr. Wirth, and Mr. Young of Alaska) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To direct that a clinical investigation of the safety and efficacy of dimethyl sulfoxide as a drug to be used by persons with arthritis be conducted through the National Institute of Arthritis, Metabolism, and Digestive Diseases.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Secretary of Health and Human Services, acting through the National Institute of Arthritis, Metabolism, and Digestive Diseases, shall conduct a clinical investigation of the safety and efficacy of dimethyl sulfoxide as a drug to be used by persons with arthritis. The Secretary shall report to Congress not later than one year after the date of the enactment of this Act the results of the investigation conducted under this Act.

This publication is available in microform.



University Microfilms International

Please send additional information for _____
(name of publication)

Name _____

Institution _____

Street _____

City _____

State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London W1N 7RA
England

**NEW JERSEY SOCIETY
OF PATHOLOGISTS
ANNUAL SPRING MEETING**

SATURDAY, JUNE 6, 1981

**at
CMDNJ-RUTGERS MEDICAL SCHOOL,
PISCATAWAY, NEW JERSEY**

8:30 A.M.—2:00 P.M.

**on
“ENVIRONMENTAL PATHOLOGY”**

Program Chairman: Bernard Wagner, M.D.

The program will contain presentations by nationally prominent speakers on the effects of drugs and chemicals on the cardiovascular system, morphological aspects of nephrotoxicity, radiation and radiation induced disease, environmental factors in lung disease, and the effects of drugs and chemicals on the liver. The program will be of interest to a cross-section of physicians, including pathologists, oncologists, and public health specialists as well as allied professionals in various public health and preventive medicine fields.

For Further Information Contact:

Cathy Gillmer
New Jersey Society of Pathologists
Two Princess Road
Lawrenceville, New Jersey 08648
Phone: (609) 896-1717

**ANNUAL AWARDS DINNER
of the
ACADEMY OF MEDICINE
OF NEW JERSEY**

Wednesday, May 27, 1981

6:00 P.M.

**at
THE CHANTICLER
Millburn, New Jersey
1981 AWARD RECIPIENTS**

**EDWARD J. ILL AWARD
JAMES A. ROGERS, M.D.**

**CITIZENS AWARD
ALAN SAGNER**

**SPECIAL HONORARY MEMBERSHIP
MORRIS H. SAFFRON, M.D., Ph.D.**

For further information on registration and seating arrangements contact the Executive Offices of the Academy: Two Princess Road
Lawrenceville, NJ 08648
(609) 896-1717

Christian Health Care Center

... since 1911

Wyckoff, New Jersey

301 Sicomac Avenue • (201) 427-2816

A private facility which offers the following services:

INPATIENT PSYCHIATRIC SERVICE

- 81 bed facility for continued care (primarily psychiatric-geriatric)
- 14 bed short term unit for women over 18 years of age

OUTPATIENT PSYCHIATRIC SERVICE

- Serving all ages with psychiatric and counselling services
- Continuing care and supervision for patients

Fully accredited by Joint Commission of the Accreditation of Hospitals.

Able to accept either voluntary or involuntary patients.

For further information regarding admission, write or call Admission Office



CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

- June**
- 10 **Lessons Learned in an Intensive Care Unit**
8-9:30 p.m.—West Jersey Hospital,
Voorhees
(*West Jersey Hospital*)

CARDIOLOGY

- June**
- 10 **Cardiology Conferences**
- 24 3:30-5:30 p.m.—Middlesex General
Hospital, New Brunswick
(*CMDNJ-Rutgers, Somerset County
Heart Assn. and AMNJ*)
- 11 **Cardiology**
7:30-9:30 p.m.—Overlook Hospital,
Summit
(*NJ Institute of Ultrasound in Medicine
and AMNJ*)
- 15 **Coronary Angiography and
Catherization**
12:30-1:30 p.m.—West Hudson
Hospital, Kearny
(*West Hudson Hospital and AMNJ*)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

- June**
- 2 **Pulmonary Diseases**
- 16 **Rheumatology**
11 a.m.—Greystone Park Psychiatric
Hospital
(*AMNJ*)
- 3 **The Treatment of Arthritis**
9:30-11:30 a.m.—St. Clare's Hospital,
Denville
(*Dover General, Riverside, and Saint
Clare's Hospitals and AMNJ*)
- 3 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—VA Medical Center,
East Orange
(*AMNJ Endocrinology Section*)
- 3 **Endometrial Carcinoma**
11:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 3 **Advances in Drug Therapy in GI Disease**
1-5 p.m.—Rutgers Medical School,
Piscataway
(*NJ Gastroenterological Society and
AMNJ*)

- 3 **Medical Lecture Series**
10 1-3 p.m.—Christ Hospital,
17 Jersey City
(*Christ Hospital and AMNJ*)
- 3 **Medical Lecture Series**
10 1-2:30 p.m.—VA Medical Center, Lyons
17 (*VA Medical Center and AMNJ*)
- 24
- 3 **General Medical and Surgical Topics**
- 17 **Medical/Surgical Clinical Conference**
11:30 a.m.—Hamilton Hospital, Trenton
(*Hamilton Hospital*)
- 4 **Medical Grand Rounds**
9:30-11 a.m.—Newark Beth Israel
Medical Center
(*AMNJ*)
- 5 **Medical Grand Rounds**
11:30 a.m.-1 p.m.—College Hospital,
Newark
(*AMNJ*)
- 5 **Renal Conferences in Nephrology**
- 19 2-3:15 p.m.—College Hospital, Newark
(*Nephrology Society of NJ and AMNJ*)
- 6 **Symposium on Asthma**
9 a.m.-4 p.m.—NJ Medical School,
Newark
(*CMDNJ and AMNJ*)
- 9 **Skin in Systemic Disease**
12 noon-2 p.m.—West Jersey Hospital,
Voorhees
(*West Jersey Hospital*)
- 9 **Hemodialysis Therapy**
- 23 **Gastrointestinal Update**
- 30 **Hyperlipidemia**
8-9 a.m.—Greater Paterson General
Hospital, Wayne
(*Greater Paterson General Hospital and
AMNJ*)
- 13 **Topics in Gastroenterology**
All day—Golden Nugget, Atlantic City
(*Underwood Memorial Hospital and
Hospital of University of Pennsylvania*)
- 16 **Treatment of Asthma**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 17 **Common Disorders of the Esophagus and
Stomach**
9-11 a.m.—West Jersey Hospital,
Voorhees
(*West Jersey Hospital*)
- 17 **Acute Renal Failure**
11 a.m.—South Bergen Hospital,
Hasbrouck Heights
(*AMNJ*)
- 17 **Dermatological Conference**
6-8 p.m.—Rutgers Community Health
Plan, 57 U.S. Highway 1, New
Brunswick
(*CMDNJ-Rutgers Medical School*)
- 18 **Advanced Life Support Systems in
Patients with Multiple Trauma**

- 5-6:30 p.m.—Somerset Medical Center,
Somerville
(*Somerset Medical Center and AMNJ*)
- 19 **End State Renal Disorder**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 19- **Symposium on Low Back Pain—**
- 20 **Non-Surgical Approach**
8-5 p.m.—NJ Medical School, Newark
(*CMDNJ and AMNJ*)

July

- 14 **Pulmonary Diseases**
8-9:30 p.m.—Shore Memorial Hospital,
Somers Point
(*Shore Memorial Hospital and AMNJ*)

NEUROLOGY/PSYCHIATRY

- June**
- 1 **Transference Psychosis**
8-10 p.m.—9 Marquette Rd., Upper
Montclair
(*Essex Psychiatric Doctors Seminars and
AMNJ*)
- 2 **Psychiatric Case Conference**
9 7:30-9:30 a.m.—Trenton
Psychiatric Hospital
- 16 **Psychiatric Hospital**
(*Trenton Psychiatric Hospital and
AMNJ*)
- 23 **Ongoing Child Psychiatry Case
Conference and Lecture**
17 8:30-10:30 a.m.—Trenton
Psychiatric Hospital
(*Trenton Psychiatric Hospital and
AMNJ*)
- 3 **Psychopharmacology for the
Health Care Professional**
9 a.m.-12:30 p.m.—Squibb World
Headquarters, Princeton
(*Carrier Foundation and AMNJ*)
- 4 **Case Presentation**
- 11 **Psychological Issues in Medicine**
- 18 11 a.m.-12 noon—Greystone Park
Psychiatric Hospital
(*Greystone Park Psychiatric Hospital and
AMNJ*)
- 4 **Multiple Personality**
- 11 **Treating the Impaired Physician**
- 18 **Therapeutic Touch**
- 25 **Endorphins Update**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(*Carrier Foundation and AMNJ*)
- 17 **The Alcoholism Rehabilitation Program:
Beyond the Medical Model**
9:15 a.m.-12:30 p.m.—Carrier
Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 23 **Clinical Future of Psychiatry**
4:30-5:30 p.m.—Carrier Foundation,
Belle Mead
(*Carrier Foundation and AMNJ*)

July

- 1 Ongoing Child Psychiatry
- 8 Case Conference and Lecture
- 15 8:30-10:30 a.m.—Trenton
- 22 Psychiatric Hospital
- 29 *(Trenton Psychiatric Hospital and AMNJ)*
- 2 Psychiatric Aspects of Disability
- 9 ECT in Treating Acute Psychosis
- 16 Violent Patients and Vicissitudes of Separation
- 23 Psychiatry Resident Shortage and Training Issues
- 30 Group Therapy
- 12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)
- 14 Medication Treatment Refusal and the Right to Treatment
- 9 a.m.-4 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)
- 16 Electromyography
- 7:30-9 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital, Dept. of Surgery)

OBSTETRICS/GYNECOLOGY

June

- 3 The Abnormal Menstrual Period
- 9-11 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)
- 25 The Menstrual Cycle
- 4-5:30 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

OPHTHALMOLOGY

June

- 4 Applications of Ultrasound in Ophthalmology
- 7:30-9:30 p.m.—United Hospitals of Newark
(NJ Institute of Ultrasound in Ophthalmology and AMNJ)

- 17 Congenital Glaucoma
- 7-9 p.m.—United Hospitals of Newark
(CMDNJ and AMNJ)

PATHOLOGY

June

- 6 Environmental Pathology
- 9 a.m.-12 noon—Rutgers Medical School, Piscataway
(NJ Society of Pathologists and AMNJ)
- 23 Enzymatic Diagnosis of Myocardial Infarction
- 9-10 a.m.—Holy Name Hospital School of Nursing, Teaneck
(Holy Name Hospital and AMNJ)

PEDIATRICS

June

- 9 Family in Genetic Crisis
- 9 a.m.-4:30 p.m.—NJ Medical School, Newark
(CMDNJ and AMNJ)
- 15 The Critically Ill Patient—Early Management
- 12 noon-1 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)
- 19 The Battered Child
- 7:45-9:15 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

RADIOLOGY

June

- 4 Ultrasound in Ophthalmology
- 7:30-9:30 p.m.—United Hospitals of Newark
(NJ Institute of Ultrasound in Ophthalmology and AMNJ)
- 11 Cardiology
- 7:30-9:30 p.m.—Overlook Hospital, Summit
(NJ Institute of Ultrasound in Medicine and AMNJ)
- 13- Real-Time, Cross Sectional

- 14 Sector Scanning
- 9 a.m.-5 p.m.—Nassau Inn, Princeton
(National Foundation for Non-Invasive Diagnostics and AMNJ)

GENERAL SURGERY

June

- 2 Primary Lesion of Melanoma
- 5-6 p.m.—Rutgers Medical School, Piscataway
(CMDNJ and AMNJ)
- 2 Tumor Conferences
- 9 12 noon-1 p.m.—Morristown Memorial Hospital
- 16 *(Morristown Memorial Hospital and AMNJ)*
- 23 Tumor Conference
- 12 noon-1 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)
- 18 An Approach to Breast Cancer
- 7:30-9 a.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)
- 23 Surgery of Chronic Obesity
- 8 p.m.—Warren Hospital, Phillipsburg
(Warren Hospital and AMNJ)

SURGICAL SPECIALTIES (includes ENT Neurosurgery, Orthopedic, Plastic, and Cardio-Vascular Surgery)

June

- 23 Pars Plana Vitrectomy
- 8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society and AMNJ)

MISCELLANEOUS

June

- 23 Health Insurance—What's It All About?
- 12 noon-2 p.m.—West Jersey Hospital, Voorhees
(West Jersey Hospital)

Dr. Renaud Blanchet

Renaud Blanchet, M.D., a member of our Cumberland County component, and a family practitioner in Vineland, died on March 10 in University of Pennsylvania Hospital after a brief illness. Born in Port-au-Prince, Haiti in 1917, Dr. Blanchet earned his medical degree from the Haitian Faculty of Medicine in 1945 and came to the United States in 1954 for graduate studies at Misericordia Hospital in Philadelphia and Good Samaritan Hospital in Pottsville, Pennsylvania. He had been in practice in Vineland since 1959 and was on the staff at Newcomb Hospital there. He was a Fellow of the American Academy of Family Practice. Dr. Blanchet was an accomplished artist and had received several awards over the years. Currently he was exhibiting colored ink drawings at the Cumberland County College Library. His subjects ranged from astronomy to witch doctors.

Dr. Nathaniel B. Cole

Nathaniel B. Cole, M.D., of Perth Amboy, a member on our Middlesex County component, died on March 23. A native of New Jersey born in 1904, Dr. Cole was graduated from George Washington University College of Medicine in 1929 and first pursued a career in ophthalmology and otolaryngology earning certification by each of those boards. He later directed his career to plastic and reconstructive surgery and held staff appointments in that field at Perth Amboy General Hospital, St. Peter's and Middlesex General Hospitals in New Brunswick, J.F. Kennedy Hospital in Edison, Memorial Hospital in South Amboy and the French Hospital in New York City, and was consultant in plastic surgery at the Jersey City Medical Center. Dr. Cole was a Fellow of the American College of Surgeons and of the International College of Surgeons. During World War II he served five years in the Medical Department of the AUS.

Dr. Charles Cunningham

Charles Cunningham, Jr., M.D., family physician, civic leader and philanthropist, died of cancer in Newcomb Hospital on March 4. A native of New Jersey, born in 1904, Dr. Cunningham earned his medical degree from Syracuse University College of Medicine in 1929 and came to Vineland the following year to establish a practice. He was a Fellow of the American Academy of Family Practice and had been affiliated with Newcomb Hospital, having served as president of the staff for eleven years. Dr. Cunningham was active in organized medicine and served a term as president of Cumberland County Medical Society. At the State level he was a member of the Public Health Council and of the Committee on Medical Student Loan. He had been health officer for Vineland since 1946 and for over 40 years served as police and fire department physician. Dr. Cunningham was a member and chairman of the board of trustees of the New Jersey State Hospital at Ancora and for three years he was chairman of the county mosquito control commission and served also as county assistant medical examiner. He was chairman of the board of trustees of the Cumberland County College and a member of the board of trustees of Hahnemann Medical College. Throughout the years he gave freely of his time and money to numerous civic and charitable organizations and received many awards in recognition. In 1973 Dr. Cunningham had donated his home to the Vineland Library and he presented the town with fourteen acres of land for a city park. Last year he was a recipient of MSNJ's Golden Merit Award noting 50 years in medical practice. During World War II, Dr. Cunningham served for six years in the medical department of the AUS, attaining the rank of colonel, and saw duty primarily in the China-India-Burma theater under General Joseph Stilwell. He was decorated by General Chiang Kai-shek and made an Honorary Colonel in the Chinese (Formosa) Army.

Dr. Daniel B. Roth

Daniel B. Roth, M.D., of Teaneck, a member of MSNJ's Committee on Publication for nine years and chairman for seven of those years, died of cancer at Englewood Hospital on March 31. Born in New York City in 1912, Dr. Roth was graduated from Long Island Medical College in 1937 and pursued a career in obstetrics and gynecology, becoming board certified. He had held staff appointments at Englewood Hospital, where he also directed the fertility clinic, at Bergen Pines County Hospital in Paramus, where he was chief of the department of obstetrics and gynecology, and at Jewish Memorial Hospital in New York City. Dr. Roth was active in organized medicine. He was a member of the Board of Trustees of his local county medical society (Bergen), editor of the Bergen County Medical Society Bulletin, a member of the Judicial Committee and chairman of the Committee on Maternal Welfare. He was a member of the Board of Trustees of the New Jersey Foundation for Health Care Evaluation and Medical Director of the Bergen County Professional Standards Review Organization. At the state society, in addition to his service with the Publication Committee, Dr. Roth had been a member of MSNJ's Committee on Maternal and Child Care for many years. He was a Fellow of the American College of Obstetricians and Gynecologists and of the International College of Surgeons.

Dr. Steven J. Stanowicz

On February 4, Steven J. Stanowicz, M.D., a member of our Warren County component, died at Hackettstown Community Hospital after a short illness. A native of Jersey City, born in 1916, Dr. Stanowicz was graduated from New York University School of Medicine, class of 1942, and following service in the medical department of the Army of the United States (Pacific Theater), he

established a general practice in Hackettstown which he had maintained until his death. He was affiliated with Newton Memorial Hospital and Warren Hospital in Phillipsburg. An athlete himself, Dr. Stanowicz had served as Hackettstown's school and athletic physician for nearly all of his years of practice. In 1978 he was recipient of the Hackettstown

Chamber of Commerce's Humanitarian Award.

Dr. Albert J. Ward

A senior member of our Morris County component, Albert J. Ward, M.D., formerly of Morristown, died at his home on Jekyll Island, Georgia, on February 26 after an extended illness. A

native of Ithaca, New York, Dr. Ward was graduated from Cornell Medical School in 1925 and pursued a career in general surgery. He had been affiliated with the Riverside Hospital in Boonton. During World War I Dr. Ward served as a non-commissioned officer in the AEF. He was 82 years old at the time of his death.

BOOK REVIEWS

Management of Endocrine Disorders

Jerome M. Hershman, M.D. Philadelphia, Lea and Febiger, 1980. Pp 259. Illustrated. (\$13.50—Paperback)

This book edited by Dr. Hershman, who wrote the chapter on thyroid disease, brings together contributions responsible for discourses on disease of the pituitary, adrenal, bone, disorders of calcium, water metabolism, male and female reproduction, obesity, hyperlipidemia, diabetes mellitus and hypoglycemia. Indeed, as stated in the preface, the book presents the diagnosis and therapy of various endocrine and metabolic disorders in a practical way and is, therefore, of interest to medical student, housestaff officers and practitioner alike.

In general, we find presented a complete differential etiological listing in most major topics with methods of therapy, and with each chapter followed by a suggested reading list for those interested in further discussion. The book certainly fulfills its stated objective which is to present a practical discussion primarily of the diagnosis and therapy of the more common endocrine and metabolic disorders. This is nicely done in the small volume of two hundred

fifty-nine pages, chockful of information, with case illustrations and which affords pleasant and valuable reading.

Mark M. Singer, M.D.

Your Fabulous Volunteers

Richard E. Harpster. Washington, NJ, Washington Emergency Squad, 1980. Pp 224. Illustrated (\$10.95)

Washington, New Jersey, population 7000, is a small town with a proud history. It was here, nearly a half century ago, that one of the nation's earliest rescue squads was established. Culled from the ranks of the town's volunteer fire department, the original 12-man squad carried their first-aid materials in a homemade cabinet installed on the running board of a ladder truck. In 1937, the resourceful Washington Emergency Squad received official recognition when it placed its own customized ambulance into service. Using a Dodge chassis purchased at cost, they had built the truck body themselves, crowning their achievement with a timeworn, newly electrified fire bell.

The squad has grown to 31 active members, 5 junior members, and a recently organized auxiliary. In 1931, the squad was summoned by a chief apparatus driver who doubled as a sleep-in

janitor. By 1979, the town had four full-time dispatchers who received 42,203 calls. With a fleet of five well-equipped ambulances and a fourteen-foot boat, the squad responded to 1389 of these calls.

Although dealing primarily with the Washington squad, the book also provides a capsule profile of the eleven additional volunteer rescue squads located within Warren County. It is illustrated with photographs of squad members, activities, buildings, and equipment, both past and present. These countywide squads respond to nearly 8000 annual calls for help.

While of interest to local area residents especially, this history of the Washington Emergency Squad can be seen from a larger perspective. Volunteer community service organizations develop in response to a recognized need. As was the case in Washington, New Jersey, an idea can be transformed into a reality by the efforts of a few dedicated and caring individuals.

The Institute for Instructional Improvement funded this publication and the author, a journalist, donated his services. All receipts from the sale of this book will benefit the squad.

Robert P. Haberkern, M.D.
Deane Lappin

PHYSICIANS

All specialties. Regularly scheduled hours, respectable salary, malpractice paid, free health/dental, 30 days paid vacation, many family benefits and more. Must qualify for commissioned officer in Navy Medical Corps.

Send C. V. to
Medical Programs Officer
128 N. Broad St.
Philadelphia, PA 19102
or call
(215) 597-9680
or 564-3820.

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 psychiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$16,100 to \$18,400 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

EMERGENCY ROOM PHYSICIAN

235-bed accredited hospital located in South Jersey, has a Full Time position available for a career oriented Physician with background or medical training in Emergency Medicine. This active Emergency Service had 25,000 visits last year. NJ license required. Liberal fringe benefits, competitive salary and paid malpractice. Coverage on equal rotation of 39 hours per week. Send CV to:



NEWCOMB HOSPITAL

65 S. State Street
Vineland, NJ 08360

JAMES J. DUNCAN
PERSONNEL DIRECTOR

Equal Opportunity Employer

NEEMA EMERGENCY MEDICAL —a professional association—

Emergency Medicine Positions—available with emergency physician group in Pa., N.Y., N.J., Va., W. Va., Md. and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical

Suite 400	or phone
399 Market Street	in Pa., (215) 925-3511
Philadelphia, Pa. 19106	outside Pa., 800-523-0776

MEDICAL DIRECTOR

Phila., Pa.

Leading preventive health corporation seeks Board Certified Internist to join our staff as Medical Director of our innovative diagnostic clinic in Philadelphia. This unique position affords the opportunity to utilize both clinical and administrative skills with an emphasis on preventive medicine, performing comprehensive examinations and consultations.

PHYSICIANS/PART-TIME

Internists (Board Certified or Eligible) also needed to work part-time, flexible days and hours, at the above clinic.

To be considered, please call our New York headquarters office (collect): (212) 486-8991.

HOME/OFFICE

Atlantic Highland's M.D. retiring from home office practice. Mint, mint 3 bedroom/1½ bath colonial on meticulously maintained grounds. Plus, 750 square foot attached office with private entrance. Nurses station, waiting room, consultation room, examining room, treatment room, dressing room, dark room and ½ bath. Doctor will assist with take-over of practice. \$137,500.

All appointments through Peter Pace

Peter Pace, Realtors 201-842-0770
850 Broad Street
Shrewsbury, New Jersey

FANTASTIC OPPORTUNITY!!!

BUY OR LEASE

Attractive 12,000 sq ft, 3 story elev professional bldg delivered vacant for immediate occupancy. Located just off a Rte 21 Interchange and one half block from the new City Hall in Passaic, NJ. Approx 4 separate suites per floor, ea w/individual heat/AC systems. 1st floor has space for commercial use such as pharmacy, etc. And best of all, the entire "operation" is realistically priced!

RACHLIN & CO, Realtors

Management Division/Our 76th Yr.
17 Academy St., Newark, NJ 07102
(201) 622-7890

OFFICE COMPLEX FOR SALE MILLTOWN, N.J.

Currently 2 physicians plus separate dental office. Owner-occupants retiring. Deluxe home adjacent. 45 min. from NYC. Medical school and hospitals close. Terms negotiable.

Call D. Fleming

FLEMING-MCLOUGHLIN GALLERY OF HOMES
201-246-0300

North Brunswick

Ideal Situation for a physician. Modern building (housing 3 dentists) 1100 sq. feet (will divide) Central business area Ample parking. Available May 15th. Call 201-249-4800

IDEAL FOR MEDICAL GROUP-MEDICAL CENTER

FOR LONG TERM LEASE—containing OPTION for FIRST REFUSAL to PURCHASE PROPERTY.

FORMER COLONIAL WYCKOFF POST OFFICE BUILDING at 378 Main Street, corner of Madison Avenue, Wyckoff, New Jersey. First Floor 3,200 square feet—Basement 2,600 square feet.

BEST LOCATION in Wyckoff in center of business area, ample street parking and on premises.

If interested—Contact Sebastian Gaeta at 386 Main Street, Wyckoff, New Jersey, telephone number (201) 891-0345 to see location and inspection of building and for lease terms.

OFFICE SPACE FOR RENT

Office space available next to a Dental Office in a new professional building located on Main Street, Manville, New Jersey. Somerset Medical Center is five minutes away. Presently, one semi retired general practitioner in town of 14,000 plus. Presents an unusual opportunity for an immediately successful practice.

Call (201) 722-2928 for additional information.

REAL ESTATE

SEE PAGE 412

SOMERVILLE

professional office building one story—
excellent parking 2 blocks from
Somerset Hospital on main
thoroughfare. We will finish to suit
Suites from 1100 sq. ft.

Knauer Realtycorp
201-526-7600

CLASSIFIED ADVERTISEMENTS

GENERAL INTERNIST—Available July 1981. Board eligible, 29, New Jersey licensed, well trained. Seeking solo, group or hospital practice. Write Dr. Shah, 100 Hospital Plaza Apt 705, Paterson, N.J. 07503. Phone (201) 279-9558.

GENERAL INTERNIST—Available July 1981. Seeking position as full-time or preferably practice as solo, associate or in group involving direct patient care. Please respond to L. Rohra (212) 458-9609.

HEMATOLOGIST-ONCOLOGIST—37, ABIM certified, board eligible in hematology. Desires to associate in or buy an established practice in New Jersey. Willing to do general internal medicine. Write Box No. 241, c/o JOURNAL MSNJ.

OB/GYN—Board eligible, seeking group or partnership opportunity. Available immediately. Write Box No. 238, c/o JOURNAL MSNJ.

PHYSICIAN—GP, desires full-time office or clinic practice. Call M.D. at (504) 272-9726 in evenings or Box No. 242, c/o JOURNAL MSNJ.

RADIOLOGIST—Fully trained radiologist is available for part-time or vacation coverage. Write Box No. 240, c/o JOURNAL MSNJ.

PHYSICIAN—For downtown Newark Industrial Clinic. Monday through Friday, 9 to 5. Good salary, excellent benefits. Call (201) 643-4969.

PEDIATRIC PRACTICE—FOR SALE—Practice has been established in Newark for 6 years. Have more than 10,000 charts. Good for pediatricians also board certified family physicians. Sale price \$5,000.00 including equipment. Write Box No. 239, c/o JOURNAL MSNJ.

NEEDED—Used x-ray equipment. 300-500 milliamperes, in good condition with or without fluoroscopy. Call (201) 240-4031 after 5 p.m.

FOR SALE—Medical and Surgical Equipment from former doctor's office, including tables, stools, cabinets, instruments, metal desk, etc. Telephone (201) 366-2557.

INFORMATION FOR MEMBERS—RATES—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT**: Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JOURNAL MSNJ" as six words. **COPY DEADLINE**: Fifth of preceding month.

HOME/OFFICE—Lawrenceville. Corner, New English Tudor House between Princeton and Trenton. Separate entry for office, office area 500 square feet. No practice for sale. Excellent for doctor and dentist. Just for the cost price. P.O. Box 6275, Lawrenceville, N.J. 08648 or call (609) 896-3167.

FOR SALE—South Jersey. Beautiful medical office, 2 apartments combination. In doctor-shortage area. Close to Philadelphia. 8 room office, lavatory; 4 bedroom 2 bath apartment; 1 bedroom income apartment. Details phone (609) 467-0466 or write Mrs. S. Lintz, Box 157, Swedesboro, N.J. 08085.

LITERATURE SEARCHES—NJMS student with graduate degrees in basic and in behavioral sciences desires to do literature searches in summer 1981. Write Box No. 231, c/o JOURNAL MSNJ.

OFFICE SPACE TO SHARE—Caldwell. Professional building. Common waiting room, private consultation room, examination rooms. Ample parking. Call (201) 228-1124.

LOOKING FOR OFFICE SPACE TO SHARE—Morris County. Preferably Morristown. Call (201) 267-5119.

OFFICE SPACE TO SHARE—Short Hills. Professional building, convenient to Overlook and St. Barnabas Hospitals. Time negotiable. (201) 379-2254.

OFFICE AVAILABLE—Elizabeth. Private medical office available immediately. 1150 square feet fully equipped and beautifully furnished and carpeted. X-ray machine, central air conditioning, parking lot, excellent location. Call (201) 643-4444 weekdays 9 to 5.

OFFICE SUITE FOR RENT—Caldwell. 800 square feet, Professional Building. Ample parking, close to Routes 80, 280, and 46. Call (201) 228-1124.

OFFICE SPACE—Cherry Hill. Lower level office available in established medical building. Suitable for most specialties. Call (609) 429-2270 9 to 4 p.m.

OFFICE AVAILABLE—Clifton. New modern Professional Building. 1200 square feet. Fully decorated. Clifton Avenue Extension. Call (201) 773-9880.

OFFICE SPACE—Edison. New modern Professional Building. Will divide. Need all specialties. On-site parking, near all major highways and hospitals. Call Dr. M. Bronstein. (201) 826-5606.

OFFICE SPACE—Englewood. 1200', can be divided. Ideal for psychiatrists and surgical specialties. Two blocks from Englewood Hospital. Ample parking. Call (201) 568-1441.

SPACE AVAILABLE—Jackson Township. Office complex recently rebuilt. Currently being occupied by one group of two obstetricians, one solo obstetrician, one general surgeon, one nephrologist, one orthopedic surgeon. Spaces available for office suites or space to share available. Call 892-9499.

OFFICE SPACE—Livingston. For rent in medical office conveniently located in Livingston. Call afternoons. (201) 994-3200.

OFFICE SPACE—Madison. 1,300 square feet, can be divided. Growing suburban area, universities, office parks, three teaching hospitals. Ten other health professionals, including x-ray and lab in building. Madison Medical Center, 28 Walnut Street, Madison, N.J. 07940.

PROFESSIONAL OFFICE FOR RENT—Morris County. Near hospital. 710 square feet. Excellent location. Telephone (201) 366-2557.

OFFICE SPACE—Morris-Passaic County. Available in an oversize medical office, newly decorated. Excellent location in Morris-Passaic County, near all major highways, 30 minutes to New York City. Phone (201) 337-1627 evenings.

OFFICE SPACE—South Amboy. Choice space opposite South Amboy Hospital. Approximately 1,000 square feet. Close to Perth Amboy Hospital (3 miles). (201) 727-1211.

LEASE OFFICE

Ophthalmologist desired to lease office space in a new medical building. Excellent promise for thriving ophthalmology practice; suitable for initial location or as a second office. Please contact:

**East Gate Medical Building
Church Street and Gaither Drive
P.O. Box 315
Mt. Laurel, N.J. 08053
609-428-4775**

OFFICE SPACE

1 doctor's office in South Orange, New Jersey in luxury building with doorman. Ample parking. Call (201) 379-3967 or 762-1007.

MOVING YOUR OFFICE

If you're planning on moving your office in or out of the North Jersey area, HEMMINGS MOVING & STORAGE CO. can be of service. We've been offering prompt, efficient, courteous service since 1924. Hourly and weight rates available. We can also coordinate the move of your residence along with your practice.

For more information, call or write:

John Hemmings
Hemmings Moving & Storage Co.
P.O. Box 596, Rt. 24W
Chester, NJ 07930
201-876-4226
201-526-6463



Mayflower

REDWOOD DECKS

Call Mike

**The Fancy Deck Builder
(201) 595-6263**

a group major medical plan for doctors

Officially Endorsed by The Medical Society of New Jersey

**BROAD COVERAGE
COMPETITIVE RATES
OPEN ENROLLMENT
JUNE AND DECEMBER**

For More Information Contact

Donald F. Smith and Associates

1 Airport Place, Route 206 North. P.O. Box 2197 • Princeton, New Jersey 08540 • (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross-Blue Shield

Journal of
the Medical
Society of

New Jersey

The Library
Acquisitions Division
Univ. of Calif., San Francisco
San Francisco, Calif 94142

LIBRARY
U.C. SAN FRANCISCO

JUN 24 1981

Partnership, Not Domination
Armando F. Goracci, M.D.

Cerebral Thrombosis
M. Geller, M.D., et al.

Physician Careers
T. G. Fox, M.D.
R. T. Blackburn, Ph.D.

HMO Status Report
S. M. Ferrand, M.H.S.A.

Complete Table of
Contents on page 416

Armando F. Goracci, M.D.

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

***Check this list
against your
coverages***

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$7,500 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

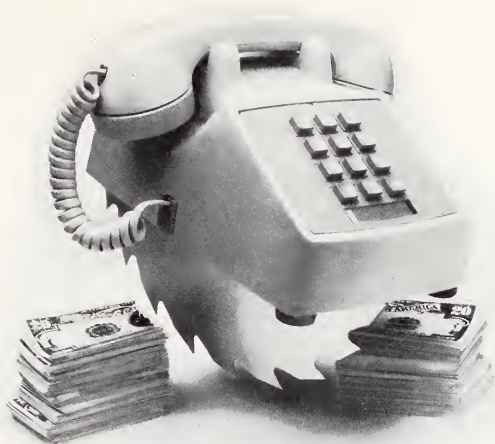
E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____



Cost Cutter!

Bell System technology can turn your office phone into a tool that boosts productivity and reduces expense.

It's as commonplace as the calendar on your desk, but connected to the latest Bell communications systems, your *telephone* can boost your productivity...increase your efficiency...and aid your cost-control efforts. These new systems feature:

Cost Control. Bell systems can help you keep detailed records of phone usage and allow restriction of long-distance calling on specified phones. And outgoing calls can be directed along the most economical routes for further savings.

Productivity. You can tailor your system by choosing from a wide range of up-to-the-minute features and services. One feature allows phone conferences without switchboard assistance...another lets you conduct business from home by connecting your home phone to your office communications system...another lets your phone calls follow you automatically when you leave your desk.

Flexibility. Bell systems can be rearranged at any time. And they're designed to be easily upgraded, swiftly adapting to changes in your practice. You can even make many of the changes yourself, thereby controlling the costs of service visits.

Reliability. New Jersey Bell offers a comprehensive service capability that is unsurpassed by our competi-

tors. And our most advanced systems are connected by remote hook-up to one of four centralized offices, where they are monitored day and night by Bell technicians.

Problems are diagnosed with computer speed, and, in many cases, corrected before your workday begins and before the problems even interfere with business.

**To speak with a
Business Communications Specialist,
call New Jersey Bell, toll-free, at
800-242-0885.**

New Jersey Bell

Direct Marketing Center
Gateway II—17th Floor
Newark, N.J. 07102

I would like to learn more about the ways my practice can benefit from a new communications system from New Jersey Bell. Please have a Business Communications Specialist call me as soon as possible.

Name

Title

Organization

Street Address

City State Zip

Telephone #

The best time to call is JMS6:81



**The knowledge
business**

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



Officers and Trustees

PRESIDENT	Armando F. Goracci, M.D. (Gloucester)	Woodbury
PRESIDENT-ELECT	Howard D. Slobodien, M.D. (Middlesex)	Perth Amboy
FIRST VICE-PRESIDENT	Alexander D. Kovacs, M.D. (Union)	Scotch Plains
SECOND VICE-PRESIDENT	Frank Y. Watson, M.D. (Essex)	Montclair
IMMEDIATE PAST-PRESIDENT	Augustus L. Baker, Jr., M.D. (Morris)	Dover
SECRETARY	Arthur Bernstein, M.D. (Essex)	East Orange
TREASURER	Rudolph C. Gering, M.D. (Mercer)	Pennington

Trustees

CHAIRMAN	
William Greifinger, M.D. (1984) (Essex)	Belleville
Meyer L. Abrams, M.D. (1982) (Burlington)	Cherry Hill
Frank Campo, M.D. (1984) (Mercer)	Trenton
Douglas M. Costabile, M.D. (1984) (Union)	Murray Hill
John J. Crosby, Jr., M.D. (1984) (Hudson)	Jersey City
Anthony P. DeSpirito, M.D. (1982) (Monmouth)	Neptune City
Ralph J. Fioretti, M.D. (1983) (Bergen)	Rochelle Park
Palma E. Formica, M.D. (1984) (Middlesex)	Old Bridge
Henry W. Fullerton, Jr., M.D. (1982) (Salem)	Carney's Point
Sherman Garrison, M.D. (1983) (Cumberland)	Bridgeton
John P. Kengeter, M.D. (1984) (Ocean)	Toms River
Myles C. Morrison, Jr., M.D. (1982) (Morris)	Morristown
Michael R. Ramundo, M.D. (1984) (Passaic)	Clifton
Bernard Robins, M.D., (1983) (Essex)	Springfield

Councilors

FIRST DISTRICT	(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1984)	Cranford
SECOND DISTRICT	(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1983)	Newton
THIRD DISTRICT	(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Albert F. Moriconi, M.D. (1982)	Trenton
FOURTH DISTRICT	(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1984)	Haddonfield
FIFTH DISTRICT	(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Ronald M. Fisher, M.D. (1983)	Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982)	Hackensack
William J. D'Elia, M.D. (1981)	Spring Lake
Frederick W. Durham, M.D. (1982)	Haddonfield
Karl T. Franzoni, M.D. (1982)	Trenton
John S. Madara, M.D. (1982)	Salem
Henry J. Mineur, M.D. (1982)	Cranford
Myles C. Morrison (1981)	Morristown

June 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Julio C. del Castillo, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

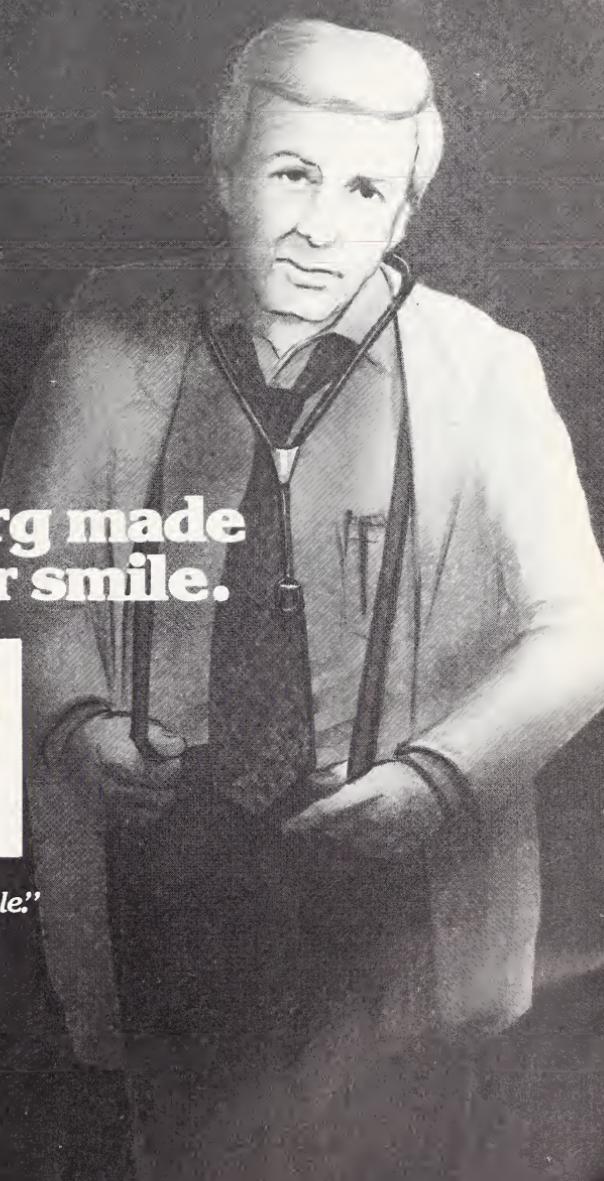
Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.
Harold Arlen, M.D.
Alfonse Cinotti, M.D.
Stuart D. Cook, M.D.
Robert Dodelson, M.D.
Wm. A. Dwyer, Jr., M.D.
Norman H. Ertel, M.D.
A. Olusegun Fayemi, M.D.
Arthur Goldfarb, M.D.
Robert A. Goldstone, M.D.
Murray Kahn, M.D.
Monroe S. Karetzky, M.D.
Avrum L. Katcher, M.D.
Sidney Ketyer, M.D.
Bernard J. Koven, M.D.
Joel D. Levinson, M.D.
Henry R. Liss, M.D.
Robert M. MacMillan, M.D.
Geobel A. Marin, M.D.
Murray Nussbaum, M.D.
Christopher M. Papa, M.D.
Victor Parsonnet, M.D.
Irwin Pollack, M.D.
Bernard A. Rineberg, M.D.
Edwin L. Rothfeld, M.D.
Benjamin F. Rush, Jr., M.D.
Morris H. Saffron, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Sheldon D. Solomon, M.D.
Lloyd N. Spindell, M.D.
A. Arthur Sugerman, M.D.
Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 925. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.



**At 4:25 PM
mild mannered
Mindy Sternberg made
a harried doctor smile.**

Mindy is part of our special Blue Shield professional relations staff. Mindy and her colleagues specialize in answering physicians' questions. You can depend on our professional relations staff for quick answers to your questions regarding claims, billing information, and contract interpretation.



*"It's our job to
make things simple."*

In addition, professional relations staff members handle the enrollment of new participating physicians, and the training of medical assistants.

So, next time you run into a Blue Shield related problem, call on us for the answer.



**Blue Shield
of New Jersey**

Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

421 PROFESSIONAL LIABILITY COMMENTARY

EDITORIALS

- 425 Armando Frank Goracci, M.D.—189th President
425 Help a Student and Help MSNJ
426 Physicians and Gun Control

429 JEMPAC REPORTORIAL

433 MSNJ AUXILIARY PRESIDENT—Phyllis Romano

ORIGINAL ARTICLES

- 435 Partnership, Not Domination
Armando F. Goracci, M.D., Woodbury
439 Cerebral Thrombosis, Platelet Aggregation and Viral Infection
M. Geller, M.D., Elmhurst, NY; A. Stier, R.N.; H. Somol, R.N.; P.B. Watson, R.D.; A.M. Naso, B.T.; M.L. Bierenbaum, M.D., Montclair; A.I. Fleischman, Ph.D. (deceased)
443 Physician Careers and an Academic Health Science Center
Thomas G. Fox, Ph.D., Piscataway; R.T. Blackburn, Ph.D., Ann Arbor, MI

CASE REPORTS

- 447 Lipoma of the True Pelvis
G. Chirovsky, M.D.; D. Lawrence, M.D.; J. Bastidas, M.D., Livingston
451 Bone Scan in the Blastic Variant of Multiple Myeloma
Louis S. Zieger, M.D.; Koson Kuroda, M.D., Camden
453 Sister Mary Joseph Node—Clue to Internal Malignancy
E.F. Schnipper, M.D.; M.J. Nissenblatt, M.D.; M. Schwartz, M.D.; S.L. Ludwig, M.D., Piscataway

SPECIAL ARTICLE

- 457 Status Report on New Jersey Health Maintenance Organizations
Shelley Meriweather Ferrand, M.H.S.A., Lawrenceville

MEDICAL-LEGAL ARTICLE

- 463 Future Medical-Legal Problems
R.E. Brennan, LL.B.; Leon G. Smith, M.D., Newark

FAREWELL ADDRESS

- 467 A View of the Presidency
Augustus L. Baker, Jr., M.D., Dover

CLINICAL NOTE

- 469 Case of "Lyme Disease" in New Jersey
Lawrence L. Ward, M.D., Fort Defiance, Arizona

471 THERAPEUTIC DRUG INFORMATION

473 NUTRITION UPDATE

475 GOLDEN MERIT AWARDS

DOCTORS' NOTEBOOK

- 477 Role of Humanities in Medical Education—Jonathan D. Klein
478 Trustees' Minutes
479 Report from the Foundation
480 Physicians Seeking Location in New Jersey
482 CMDNJ Notes

483 CME CALENDAR

484 OBITUARIES

485 BOOK REVIEW

Cover

Armando F. Goracci, M.D., 189th President of the Medical Society of New Jersey. Dr. Goracci assumed the office at ceremonies held on May 17, 1981. He is a surgeon from Woodbury. (See editorial, page 425, this issue.)



NJR Welcomes Orthotic and Prosthetic Consultations

Consultation with an Orthotic and Prosthetic expert before an amputation is making speedier rehabilitation possible, since it allows the surgeon to plan his operation to conform best with the replacement device.

Unfortunately, there are very few certified Orthotists and Prosthetists. Simon Chang, chief of NJR's Orthotic and Prosthetic lab, is among the experts who regularly provide such pre-operative information. He is also one of less than two dozen people in the country who can make certain extremely complicated devices.

For information on NJR's Orthotic and Prosthetic Consultation Service, please phone Bertrand J. Bensam, MD, at (201) 673-1860. Rehabilitation is a total team effort.



New Jersey Rehabilitation Hospital

Owned and operated by Moderncare Centers of America, Inc.

240 Central Avenue, East Orange, NJ 07018 • 201-673-1860

Bertrand J. Bensam, MD, Medical Director • Stanley Shepard, Administrator

Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities and the American Board for Certification in Orthotics and Prosthetics Inc.

Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white glossy

prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

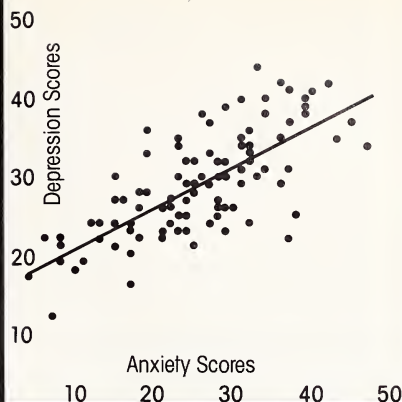
REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.

The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scales in 100 nonpsychotic psychiatric patients. The coefficient of correlation is 0.7. As depression increased, so did the anxiety levels.¹



WHY MORE PHYSICIANS ARE CHOOSING LIMBITROL

It fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician¹ found a correlation of 0.7 in anxiety and depression scores; another² has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

It is more appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression. These contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.^{2,3}

It avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Claghorn J: *Psychosomatics* 11: 438-441, Sept-Oct 1970. 2. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977; p. 316. 3. Baldessarini RJ, Tarsy D: Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p. 999.

in moderate to severe depression and anxiety

Limbitrol[®] ^{IV}

Tablets 5-12.5 each containing 5 mg chloriazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chloriazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

because it's specific for anxious depression in the nonpsychotic patient

ROCHE[®]

Please see summary of complete product information on following page.

LIMBITROL® TABLETS *Tranquilizer—Antidepressant*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of QT interval have been reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Use in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies.

Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chloridazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chloridazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely. The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, myositis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chloridazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chloridazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; 161-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

CERTIFIED G.I.A. DIAMOND INVESTMENTS

We sell at wholesale prices only diamonds that carry the Gemologist Institute of America, G.I.A. Certification of carat, grade, clarity and proportions.

We can shape an investment portfolio for your needs. Tax shelters, pension plans or simply a certifiable investment.

(201) 544-9272

METROPOLITAN INVESTMENT CO.

A Division of Metropolitan Refiners & Precious Metals

See our ad on
page 432.

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

Featuring: President of LACMA Sees No Malpractice Crisis

PRESIDENT OF LACMA SEES NO MALPRACTICE CRISIS

Edward Zalta, M.D., President of the Los Angeles County Medical Association, is not concerned that a malpractice crisis will materialize, at least not in California.

Dr. Zalta, in the "President's Report" of the *LACMA Physician*, states that figures for California during the past five years do not demonstrate an increase in the severity or frequency of malpractice claims—in fact the indicators suggest a leveling off of medical malpractice claims. Although paid claims may produce a slight increase for 1981, "when adjusted for inflation, the downward trend noted since 1975 will undoubtedly continue." Paid claims in California for 1980 were 45 percent of the paid claims in 1975, "when expressed in 1975 dollars," and considering the fact that physician population has increased 25 percent during the same period of time, the premise presented becomes more meaningful.

"The rate increases by the doctor-owned carriers were a value judgment based on trends and a desire not to be caught short or be forced to increase premiums substantially in any one year. I do not share their philosophy.

"If the rate increases prove to have been unnecessary, the excess will enure to the benefit of the policyholders and thus will be less painful to accept than rate increases applied by corporations where excess premiums are retained as profits.

"I remain convinced today as I was in 1979. I do not foresee a malpractice crisis in 1981 in California. I do foresee the need for a refinement and class rate setting by utilizing known risk factors rather than the present eight to twelve broad classifications. Physicians avoiding those procedures and facilities known to be high risk should be rated differently from those who fail to avoid such facilities." *President's Report, LACMA Physician*, March 9, 1981.

CALIFORNIA WRONGFUL LIFE ENDORSES NJ DISSENTING JUDGES

A California appellate court has held that a child has a cause of action against a physician who did not inform the parents that the child would be born with a genetic defect. This decision endorsed the views taken in the dissents of Justice Jacobs in *Gleitman v Cosgrove*, 49 NJ 22 (1967) and Justice Handler in *Berman v Allen*, 80 NJ 421 (1979).

In the *Gleitman* case an infant was born with serious impairments resulting from German measles contracted during the first trimester of pregnancy. The defendant physician, aware of the danger, failed to inform the mother of the potential harm for the child.

The majority decision of the Court barred recovery because it could not "balance the value of life with impairments against the value of no life at all, if abortion had been practiced. By asserting that he should not have been born, the infant plaintiff made it impossible for the court to measure damages."

Justice Jacobs in his dissenting remarks stated "the majority permits a wrong with serious consequential injury to go wholly unredressed. That provides no deterrent to professional responsibility and is neither just nor compatible with expanding principles of liability in the field of torts."

The Berman case was concerned with the birth of a Down's syndrome child. The Court stated a cause of action regarding the emotional distress of the parents, but not for compensation for the expenses for the child's care. Justice Handler in his dissent stated, "the child . . . was owed . . . during its gestation a duty of reasonable care from the same physician who undertook to care for its mother . . . and that duty, to render complete and competent medical advice, was seriously breached." Justice Handler also noted that physicians had, under these circumstances, a duty to the parent to present the opportunity to decide on the existence or nonexistence of their child.

A recent *NJ Law Journal* editorial entitled, "Wrongful Life—The Label That Traps: Gleitman and Berman Revisited," recommends a reexamination of the "wrongful life" issue. The following is from that editorial:

"To say, as our Supreme Court has, that infant plaintiffs are 'suing for their wrongful lives' fails to perceive the true basis of the children's complaints. The wrong actually being complained of, as Justice Jacobs and Justice Handler pointed out, is the failure to disclose material information. Armed with this knowledge, potential parents could have faced their awful choice with full information. The child and the parents are hurt if the parents are not adequately informed. In using the tag of 'wrongful life' the Court has assumed its conclusion and eliminated the right that the law would otherwise give to the parents to decide for themselves and as the representatives of their unborn child.

"A genetically impaired child who asserts that his or her parents would have avoided the child's birth had adequate information been disclosed to them need not be taken as asserting, as our Supreme Court would have it in Berman, that the child's life is 'less precious than those of others whose defects are less pervasive or less severe.' The child is merely asserting that the decision whether the child would have been better off not having been born should be left with the child's 'parental guardians,' its parents. The law can best protect potential children by not immunizing from liability those in the medical field providing inadequate guidance to the children's parents.

"Once the misdescription 'suing for their wrongful lives' is discarded, the difficulty in conceptualizing an injury to the child is no greater for genetic impairments than for any other suffering flowing from a physician's depriving the parents of

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

the authority to make a health-care decision on the child's behalf. The measurement of damages resulting from the harm depends on the facts of each case, including the benefit of life itself, a factor that may overshadow the harm if the genetic impairment is a mild one. Describing the child's action as one for 'wrongful life' has led the judges to demur, with false modesty, that they cannot intrude into a 'mystery more properly to be left to the philosophers and the theologians,' and also to remove the action from the common law of injuries and remedies.

"Our Supreme Court has denied recovery for the child's injury and for the expenses involved because professional liability would otherwise be greatly increased. This is merely to pretend that the costs created by professionals' wrongful conduct do not exist when in fact they are merely less visible, being borne by the victims or by the state and other groups in society. The California decision should prompt us to take another look at the views of our dissenting justices in *Gleitman and Berman*."

WILL "FETAL RIGHTS" BE DECADE'S BATTLE CRY, SETTING PATTERN FOR NEW TRENDS IN LITIGATION?

As "civil rights" and "human rights" became legislative and judicial rallying calls at the end of the '60s and '70s, litigation trends in recent months are sounding off on "fetal rights" as this decade's battle cry.

"Fetus suits are cropping up all over," says National Abortion Rights Action League lobbyist Suelen Lowry. "They're trying to give personhood to a fertilized egg. They want to do it legislatively, but they also want court cases." Added attorney Arkie Byrd of the Women's Legal Defense Fund: "If courts accept fetuses as having full rights as persons, a husband who didn't want his wife to have an abortion could sue her for loss of life."

The latest in a series of pertinent court decisions came last month when a Washington, D.C. jury awarded \$75,000 in a medical malpractice suit filed on behalf of a dead fetus. The hospital and physician defendants argued that a fetus had no legal right to sue because it isn't a person. But Superior Court Judge Leonard Braman let the trial proceed, saying he would decide that issue later. (*Pinckney v. Werner*, C.A. 1580-80.) Because of a jury split, a mistrial was declared on the hospital's liability, but Edward C. Werner, M.D., was found liable in the death of the fetus, whose parents had sued for \$192,000 by calculating earning potential of the resulting child.

An analysis by *National Law Journal* staff reporter Ruth Marcus notes that as anti-abortion forces urge Congress to pass an amendment that would define life as starting from the moment of conception—and therefore ban abortion—"more courts are being asked to decide that tricky question on their own. And some, perhaps anticipating Congressional action or being influenced by the tenor of the times, have been giving fetuses various legal rights. This emerging trend could affect cases from workers' compensation claims to homicides." Other fetal rights "trend" cases include the following:

... The Georgia Supreme Court in a February 3 opinion,

held that a mother whose religious practices forbade a cesarean section was required to have the operation anyway because the fetus, viable at 39 weeks, was endangered.

... A Rhode Island Superior Court judge held December 31 that a motorist who caused an accident in which a pregnant woman lost her near-term fetus could be held criminally liable for its death.

... The Alabama Supreme Court ruled February 6 that an unborn child is a family member covered by an automobile insurance policy. Severely injured in a traffic accident, the mother gave birth while in a coma to a child who died next day. The court specifically held that the viability of the 20-week-old fetus was not at issue—thus laying new ground around the landmark U.S. Supreme Court ruling (*Roe v. Wade*, 410 U.S. 113) which declared that the state has a compelling interest in the fetus at its points of viability.

Already insurance carriers are worried about the sharp increase in the number of malpractice suits related to birth-damaged infants. Recent court developments raise a new concern—that liability could be imposed for the death or damages to a fetus almost from the moment of conception. *Malpractice Lifeline*, Vol. 6, No. 3, March 30, 1981.

DID YOU KNOW

... The Medical Society of Georgia and the St. Paul Fire and Marine Insurance Co. have cooperated in developing a risk management program which gives premium reductions to physicians. The program has a series of one and a half-day intensive educational workshops designed to teach physicians laws which affect them, causes of action in the state, and methods to minimizing claims exposure. Participating physicians will receive a ten percent premium reduction the first year, eight percent the second year, and six percent the third year.

... An increase in reported claims and higher settlement costs have resulted in Aetna raising premium rates by 25 percent for the physicians of the Medical Society of Delaware.

... Medical Liability Insurance Co. of New York, the largest of the physician-owned companies, may face another premium increase. Last year its 18,000 member's premium rate was increased by 24 percent. The average claims cost in 1980 was nearly \$30,000, but actuarial projections for 1981 are \$54,000. "This is relatively modest compared to the estimates of the commercial insurance companies ... who think the average cost will be in excess of \$100,000," commented Arthur J. Mannix, Jr., M.D., President of MLIC.

... Pending final approval of the State Medical Association's House of Delegates, Georgia physicians will be a step closer to forming their own professional liability insurance company in early May.

... Malpractice premiums may be dropping for lawyers as opposed to rate increases for physicians but St. Paul's and Aetna predict the gap will close as claims and payouts increase for lawyers.

... A Georgia court has ruled a nurse to be an expert medical witness when the testimony is about a procedure that is not performed exclusively by the physician ... *Medical Economics*, March 16, 1980.

for "cardiac separation"...



Although over 80% of post-coronary patients can resume normal marital sexual activity, fear of anginal pain often results in "cardiac separation" between patients and their families.

You can help minimize "cardiac separation" with a program of

counseling and often, with a prescription for Cardilate® (erythrityl tetranitrate).

Cardilate® increases exercise tolerance, helps patients return to more normal levels of activity—including sexual activity. Sublingually, Cardilate begins to

work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to 2 hours.

counsel &
Cardilate®
(erythrityl tetranitrate)

CARDILATE® (ERYTHRITYL TETRANITRATE)

INDICATIONS: Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

CONTRAINDICATIONS: Idiosyncrasy to this drug.

WARNING: Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Intracocular pressure is increased; therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspira-

tion and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION

Oral/Sublingual Tablets: Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg, prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED:

CARDILATE (Erythrityl Tetranitrate) TABLETS (Scored):
for ORAL or SUBLINGUAL USE: 5 mg, Bottle of 100,
10 mg, Bottles of 100 and 1000; 15 mg, Bottle of 100

Reference: 1. Hellerstein HK, Friedman EH. Sexual activity and the postcoronary patient. Arch Intern Med 125:987-1970.

Burroughs Wellcome Co.,
Research Triangle Park, North Carolina 27709





The President and His Lady

Armando Frank Goracci, M.D.—189th President

Woodbury, New Jersey justly can be proud of Dr. Armando F. Goracci, the newly elected President of the Medical Society of New Jersey, for he is only the second physician from that town—and the only one in the modern era—to reach that esteemed office since 1766. The 56th President, Joseph Fithian, a fellow Woodburian, was elected in 1849.

Dr. Goracci, a surgeon, received his undergraduate and medical education at the University of Scranton (Pennsylvania) and the University of St. Louis, Missouri, respectively. After interning at the Scranton State Hospital, he had residency training at the same institution and later at the Doctors Hospital and the Jefferson Hospital in Philadelphia. He was the Ross V. Patterson Fellow of Surgery at Jefferson from 1951 to 1952.

Armand was certified by the American Board of Surgery in 1952 and has attained active staff positions in Philadelphia at the Thomas Jefferson University Hospital, where he rose from assistant in anatomy to his present title as clinical assistant professor of surgery, the Doctors Hospital and the Philadelphia General Hospital. He was chief of surgery and medical director of the Pennsylvania State Correctional Institution in Philadelphia from 1958 to 1970. He has been affiliated with the Underwood-Memorial Hospital in Woodbury since 1952 and has attained positions as attending surgeon, chief and chairman of the department of surgery at the institution. He was elected a Fellow of the American College of Surgeons in 1956.

Between all this medical training and service, Dr. Goracci took time to serve his country through military service as a first lieutenant in the Army Medical Reserve in 1943 and on active duty from 1945 to 1947. He received an honorable discharge with the rank of captain.

The recitation of Dr. Goracci's memberships in scientific and professional organizations and his positions and offices in organized medicine over the years clarify his rise to the

presidency of this Society in 1981. He joined the AMA in 1943 and was a member of the Philadelphia County Medical Society from 1952 until he transferred to the Gloucester County Medical Society in 1967. At the county level, he served as Treasurer, Secretary, President-Elect, President, Chairman of the Judicial Committee and Delegate to MSNJ. Dr. Goracci has been a member of the Board of Trustees of the Medical Society of New Jersey since 1976 and has served on numerous councils and committees.

Trusteeship is not new to this successful surgeon, as he has been a Trustee of the Academy of Medicine of New Jersey, Doctors Hospital, and the Underwood-Memorial Hospital in Woodbury. He also has been honored by life membership in the Alumni Association of Jefferson Medical College.

It is obvious that Jefferson Medical College has played and continues to play a central role in Armand's life. His wife, the former Constance Pierce Lemmon, is the daughter of the late William T. Lemmon, professor of anatomy and surgery at that institution. A Mount Holyoke graduate, Mrs. Goracci is a gourmet cook and has owned and competed with show horses all of her life. At present she collects horse-drawn carriages and owns carriage horses, as well as a horse-drawn sleigh which gets use when the winter weather permits. The present affiliation with Jefferson is the Goracci's daughter, Grace, who is a student at Jefferson Medical College.

Armand "used to" play golf and do a lot of fishing, but presently his recreation consists of gardening and a good deal of world traveling. Trips to many places in Europe, North and South America and the Orient have been highlights.

The son of Italian immigrants to the United States—his father was a coal miner in Old Forge, Pennsylvania—Armand Goracci is a credit to his heritage, his family, his town and his medical school and medical organizations. We congratulate our newly elected President and wish him a healthy and successful term of office.

A.K.

Help a Student and Help MSNJ

How would you like to help a student, help your Medical Society and its *Journal*, and make yourself feel pleased for a minimal effort and expense?

The best source of new members for MSNJ is the pool of students in the College of Medicine and Dentistry of New Jersey and the large number of resident physicians, fellows, and house officers in the hospitals in our State. There is no better way to acquaint this group of scholars with our

Medical Society and with medicine in New Jersey than to afford them the opportunity to read this *Journal* regularly. The 320-odd CMDNJ students who are members of the Medical Society of New Jersey Student Association receive *The Journal* as a benefit of membership, but there are many others who do not have access to it.

Such features as the Professional Liability Commentary, the Board of Trustees' Minutes, the Report from the New

Jersey Foundation for Health Care Evaluation and the JEMPAC Reportorial can provide them with New Jersey information not available in other journals. Our regular medical history articles will promote a sense of pride in our State's medical forerunners. The CME Calendar can keep the students and residents alert to conferences and lectures they otherwise might miss.

If you are sold on the idea, think of one or more students or physicians-in-training and sponsor them to a subscription to JMSNJ by sending a check for \$10 for each one-year subscription with the name and address of the student to: *The Journal of the Medical Society of New Jersey*, Two Princess Road, Lawrenceville, NJ 08648.

Do it now! It's a triple bargain.

A.K.

Physicians and Gun Control

Within seconds after the trigger of a handgun is squeezed and the bullet enters its human target, shouts of "Call the doctor," "Call an ambulance," are heard. Physicians—whether they like it or not—*must* have an opinion on gun control in much the same way as they must have an opinion on the prevention of nuclear warfare.

The statistics on the subject are enough to make one's hair stand on end:

1. There is an estimated arsenal of 55 million automatic handguns and revolvers in the United States, i.e., one pistol for every four Americans.
 2. A handgun is sold every 13 seconds in this country.
 3. In 1980, the United States imported 298,689 foreign-made handguns and 3.1 million gun parts. Most come from Italy and West Germany.
 4. There is a single factory in West Germany that makes and ships the guns and gun parts which are the cheap "Saturday night specials" used so regularly for violent crime in this country.
 5. Half the 20,000 homicides each year are unpremeditated or unintended, but result from explosive anger between individuals in a family or social circle—husband and wife, parents and children, lovers or drinking companions. Guns are a factor in more than half such murders.
 6. Most banks are robbed by neophytic amateurs with handguns as the persuaders.
 7. According to sociologist Glenn Pierce of Northeastern University in Massachusetts, "people with guns are far more likely to kill people than those armed with any other weapon."
 8. The U.S. holds the world's non-Olympic record hands down for murder: 9.7 murders a year per 100,000 population as compared with 1.6 in Japan and 1.3 in Great Britain and West Germany. New Orleans has a murder rate of 23 per 100,000.
 9. U.S. gun regulations are by far the most widespread in the world (some 25,000 regulations, mostly at state and local level)—and the most ineffective.
 10. Poll after poll in America has shown that most citizens want tighter gun control laws.
 11. Only 73 percent of the murderers in the U.S. are arrested; conviction rates are abysmal. Even Sirhan Sirhan, the assassin of Robert Kennedy, is eligible for parole in 1984.
- The ready availability of cheap or expensive handguns is predicated on outmoded and discredited concepts and attitudes which purportedly were based on a constitutional

right to bear arms, an inherent and fundamental right to self defense. The opponents of gun control invoke such sterile arguments, but also weep crocodile tears about interference with sporting events, target shooting for recreation, and gun collecting. Flimsy as this chain of reasoning may be, the powerful U.S. gun lobby, led by the National Rifle Association with an annual budget of \$30 million and almost two million members, has used it effectively to prevent any meaningful attempts at gun control as a step toward violent crime control.

When the bullets ripped into the chest of President Ronald Reagan, the brain of White House press secretary James Brady, the abdomen of Secret Service agent Timothy J. McCarthy and the neck and shoulder of D.C. policeman Thomas K. Delahanty most of us were having office hours, making hospital rounds or performing surgery, or attending medical conferences or meetings. It is a sure bet that we all relived similar feelings—*déjà vu*, if you will—of other days with other victims: the Kennedy brothers, Lee Harvey Oswald (murderer and murdered), George Wallace, Martin Luther King, John Lennon, Dr. Michael J. Halberstam* and many others inside and outside of the United States. Like the public, we listened to and read the press releases with great interest and took pride in the public image of George Washington University Hospital's medical spokesman, Dr. Dennis O'Leary and the trauma team which helped the victims. Unlike the non-professional public, we physicians were able personally and viscerally to identify with the feelings of the attending physicians and surgeons—Benjamin L. Aaron, Joseph M. Giordano, Arthur Kobrine, Neofytos Tsangaris—who made up the trauma team along with countless nurses, technicians and professional support personnel. Behind the headlines, there is the sight and smell of the postoperative neurosurgical patient with bulging eyeballs, motionless limbs, caked tongue and the constant and endless ministrations, observations, treatment procedures, preventive and therapeutic decisions of the intensive care unit staff with which we are all too familiar.

And to think that it all started with the distorted thinking of a sociopath who plunked a few dollars on the counter of Rocky's Pawn Shop in Dallas, Texas and walked off with Röhn GmbH Model 14, serial number L731332, a short barrel .22 caliber revolver. This gun was not for a sports event or recreational target practice or for a collection to be viewed, cleaned and displayed and kept as an investment—a hedge against inflation. It was not to bear arms to protect one's home or country. It was to commit murder—assassination, which now has been called "the American Disease."

If, indeed, assassination is the "American Disease," then

*Since this editorial was written Pope John Paul II was shot by a handgun in an assassination attempt.

American Medicine must have an active interest in its prevention. To formulate a program to control such a pervasive plague, the majority of whose victims get one-time headlines ("Two women shot at flea market; patron jailed"—*Trenton Times*), will not be easy. But eradication of smallpox and paralytic polio was not easy. Unfortunately, the psychopathy and sociopathy of human beings is less predictable and less amenable to change than the microbiology of bacteria, viruses and other lesser "creatures." We probably will have a cure for cancer and diabetes long before we have a workable prevention for murder and mayhem.

But, we physicians must have opinions and we must express such opinions on a one-to-one basis and at the highest levels of government. We cannot be displaced from good sense—medically and sociologically—by fraudulent arguments from the anti-gun control lobby: gun laws will not keep criminals from acquiring weapons and that only the "good guys" will be weaponless; guns don't kill people, people kill people; banning guns in New Jersey is meaningless if Pennsylvania has a lax law; you can't control the illegal resale of handguns or the underworld black market; federal gun control legislation is unconstitutional and un-American.

It is utter nonsense to believe that the honest citizen with a handgun can protect himself and his family against the armed criminal, who always has the advantage of the first strike. Defensive shootouts by the unskilled individual are more likely to cause injury or death to a relative or innocent bystander than to halt a violent crime in progress. Policemen themselves rank high on the list of handgun victims, so what chance does the untrained layman have?

There is no easy solution and there never will be. However, physicians are deeply involved in this terrible disorder:

1. The Victims—Physicians must patch them up or explain to the family of the deceased, when treatment fails.

2. The Perpetrators—Physicians regularly contact many citizens and have a sense of their potential for violent behavior. We should be aware of the hostile and aggressive personality who is prone to berserk conduct—child abuse, wife or husband or parent abuse. We should know the types of mental illness, psychopathy and sociopathy which lead to destructive behavior and try to recognize and, in some way,

to help those individuals while protecting the best interests of society. Physicians must have a low threshold toward the recognition of alcohol abuse and drug abuse which so often are associated with violent behavior directed toward self and others.

3. Society—Citizens look to American Medicine for guidance on all problems which have real or potential health and social components. We owe them a clearcut unequivocal answer on the question of our position on violent crime and handgun control.

What is the answer? Obviously there is no simple, single program against this American Disease. Some facets which physicians can support may be the following:

1. Strict and meaningful handgun control regulations which include as careful an evaluation of the purchaser of a handgun as possible. This could include a physician's judgment of the mental stability and his personal knowledge of drug and chemical substance abuse by the intended handgun purchaser. We prepare reports and give opinions quite readily for insurance companies and motor vehicle licensing agencies as to the safety of an individual as a truck, bus or auto driver. Why not give the governmental licensing authorities some help in the decision as to handgun registration and licensure?

2. The medical profession—at county, state and national level—should deal with this problem in an organized fashion through research, conferences and professional education. A program of prevention and control, with active physician participation, should evolve. We should encourage government not to abandon financial support for social research into such matters. It will be the work of social scientists which will unravel the mystery of the sociopathic assassin.

3. The position of American Medicine on handgun control should be documented and made known to our government and our people. We cannot afford the luxury of a non-opinion, which essentially ignores a social disease which kills more people than war and many diseases, and which snuffs out the lives of many of our most talented citizens as well as ordinary breadwinners.

Doctor, formulate your opinion on handgun control and let it be known!

A.K.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide: In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When Impotence is due to androgenic deficiency.

Android[®] / ^{Buccal}5 / ^{Oral}10 / ^{Oral}25
mg. mg. mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-pubertal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



REAPPORTIONMENT—ONE LESS FOR NEW JERSEY

The final national population count of 226,504,824 has been reported to the President. This represents 11.4 percent increase from the 1970 census and will result in the reapportionment of members to the House of Representatives. The shift in the population from the Frost Belt (Northeast-Great Lake States) to the Sun Belt (Southwestern States) will see eleven states gaining representation and ten states, including New Jersey, losing representation.

To say that the 1980 decennial census is controversial is an understatement. The major problem is the so-called "undercount" of minorities in the larger cities and industrial states. A number of court cases almost threatened to delay the census indefinitely, but in a last-minute reprieve the Supreme Court granted a stay in these "undercount" cases. This action allowed the President to receive the state-by-state population totals and the number of congressional districts per state from the Department of Commerce on time. The city and county totals needed for redistricting were received by the states on April 1, 1981. The Supreme Court action only temporarily slowed the "undercount" controversy and the cases still will have to be tried but this will not begin until mid to late February 1982. The Census Bureau also feels that these cases will not affect the release of the technical county and state totals or the redistricting in the individual states.

In New Jersey, the state legislature which is empowered to handle redistricting, will establish a legislative committee to study and present recommendations to the legislature. The membership of the committee is determined by the majority party.

Once the apportionment bill reaches the floor, a simple majority is needed for passage. Before the bill becomes a law it must be signed by the Governor.

Those states gaining seats are: Florida (4), Texas (3), California (2), Arizona (1), Colorado (1), Nevada (1), New Mexico (1), Oregon (1), Tennessee (1), Utah (1), and Washington (1). Those states losing seats are: New York (5), Pennsylvania (2), Ohio (2), Illinois (2), Indiana (1), Massachusetts (1), Michigan (2), Missouri (1), New Jersey (1), and South Dakota (1).

THE GERRYMANDER—WHAT IT MEANS AND WHAT IT DOES

The practice of "gerrymandering"—the excessive manipulation of the shape of a legislative district to benefit a certain incumbent or party—is probably as old as the Republic, but the name originated in 1812. In that year, the Massachusetts Legislature carved out of Essex County a district which historian John Fiske said had a "dragonlike contour." When the painter, Gilbert Stuart, saw the misshapen district, he pencilled in a head, wings, and claws and exclaimed: "That will do for a salamander!," to which editor Benjamin Russell

replied: "Better say a Gerrymander" after Elbridge Gerry, then Governor of Massachusetts.

There are two basic types of gerrymandering. First is the "incumbent survival" plan, aimed simply to preserve incumbent legislators. This is achieved by increasing the number of registered voters in an incumbent's district. The telltale signs of this plan are increased majorities for all or most incumbents, reduction in two-party competition, or even elimination of electoral challenges in many districts. The second is the "majority party" plan, aimed at maintaining or adding to the number of seats held by the majority party. The basic technique is to waste votes for the opposition party. This may be achieved by concentrating votes of the minority party in a few districts. These districts then produce huge majorities for the minority party members, but prevent or eliminate minority party competition in other districts. Another way to waste votes for a majority party is to disperse the vote of the opposition party. By dividing up concentrated areas of minority strength, so minority voters always will fall short of a majority in these districts, the majority party wins additional seats. Finally, the "majority party" plan can be used by establishing multimember districts that limit the voting strength of the minority party. The telltale sign of a "majority party" plan is the percentage of seats held by the majority and the fact that they are significantly higher than the party's percentage in the most recent election.

MSNJ'S POSITION ON PROPOSED NJ LEGISLATION

Senate-1557—Joseph Merlino, (13th District, Part of Mercer)

Increases medical witness fees under workmen's compensation to \$250 maximum per individual and \$750 maximum in aggregate. **ACTIVE SUPPORT.** Assigned to:

Labor, Industry and Professions Committee: Eugene Bedell, James Galdieri, John Gregorio, Brian Kennedy, James Wallwork.

Assembly-1643—Marie Muhler, (11th District, Part of Monmouth)

To require physician or optometrist who examines a person for eyeglasses or contact lenses to provide such person with the written prescription. **ACTIVE OPPOSITION,** to that portion the bill referring to contact lenses, because MSNJ does not feel it would be beneficial to the health of the consumer. Contact lenses improperly used or fitted may cause irreparable damage to the cornea. The fitting of contact lenses should be done by the prescribing ophthalmologist or optometrist. Assigned to:

Commerce, Industry and Professions Committee: Byron Bear, David Schwartz, Dennis Riley, Robert Hollenbeck, Arthur Albohn, Gerald Cardinale, S.M. Terry La Corte.

We urge you to write to the sponsors, the committee and committee members to make MSNJ's views known—c/o the State House, Trenton, NJ 08625.

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to decrease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgeable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ®, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.


Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. Adults: Anxiety disorders, symptoms of anxiety: 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. Geriatric or debilitated patients: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) Children: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.

 Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Record Programs, Inc.

6 Main Street
Madison, N.J. 07940

Specialists in color coded filing systems

Space saving shelving

*Alphabetical, numeric and
alpha numeric systems*

Consultation at no charge

Call collect or write for your free catalog
201-822-2424

X-RAY SCRAP SALVAGE

We will purchase at highest possible prices your used x-rays, silver flake or hypo solution. We will microfilm if necessary for your insurance. Settlement in cash, check or non taxable transfer of precious metals. Engelhard 999 Silver Bars, Krugerands, or Diamonds.

We also carry silver recovery machines.

(201) 544-8898

Metropolitan Refiners & Precious Metals

**264 Hwy. #35
Eatontown, N.J. 07724**

See our ad on
page 420.

Phyllis Romano—President MSNJ Auxiliary



Phyllis Romano of Dunellen has been elected the 55th President of the Medical Society of New Jersey Auxiliary.

Born and educated in New York schools, including City College of New York, Mrs. Romano has been involved in medical activities in this state since 1946, when her husband, Dr. Frank R. Romano, started his general surgical practice. She became a member of the Union County Medical Auxiliary and filled many offices and committee chairmanships which culminated in her election as president of that organization in 1960. At the state level Phyllis served a string of offices as treasurer, corresponding secretary, second vice-president, first vice-president and president-elect over the years. She also chaired a number of committees including, Widows and Orphans, Membership, Seminars and Convention, and was vice-chairman of AMA/ERF for several years.

Mrs. Romano programmed and coordinated a half-hour weekly radio series cosponsored by the Union County Medical Society and its Auxiliary. This program dealt with health care issues of public interest, medical legislation and medical education, and featured interviews with member physicians and other professional guests. For her leadership in the radio field, she was given the good-citizen-of-the-year award by the Somerset County 4-H Club.

She initiated and still manages the Dunellen/Greenbrook Rotary Thrift Shop for which she was designated a Paul Harris Fellow of Rotary International by the Dunellen/Greenbrook Rotary, one of the few women to receive this prestigious award. Phyllis was instrumental in coordinating the "Professionals for Bateman" section of

Senator Bateman's unsuccessful run for Governor. A film made by AMPAC of her political activities during this campaign still is being used all over the country as a model for this type of activity.

In addition to working fulltime for her husband as office administrator, she is treasurer of the Palm Twig of Muhlenberg Hospital in Plainfield, director and budget chairman of the Women's Auxiliary of the American Society of Abdominal Surgeons, a Eucharistic minister of her parish, and has been secretary of JEMPAC since 1979 and parliamentarian of the Union County Medical Society Auxiliary since 1970.

Phyllis married Dr. Romano in 1941 and during the period of her husband's military service in the Pacific war theater worked as a secretary in an art gallery devoted to the works of war artist-correspondents at World War II front line areas.

Phyllis and Frank have three children. Daughter Patricia is vice-president and laboratory director of Metpath, an adjunct assistant attending pathologist at St. Luke's Roosevelt Hospital Center in New York, member of the Bergen County Medical Society and married to Dr. Alfio Raciti, a general surgeon. Son Frank, Jr., an internist, is in his last year of an ophthalmology residency at the University of South Carolina Eye Research Institute. Son Paul is a third-year medical student.

Congratulations and best wishes to Phyllis Romano during her term in the office of President of the Auxiliary.
A.K.



works well in your office...

NEOSPORIN® Ointment (polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.

- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.

- It contains three antibiotics that are rarely used systemically.

- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Partnership, Not Domination*

ARMANDO F. GORACCI, M.D., Woodbury

The fluid relationship between medical education, medical economics and health care is reviewed. In relation to DRG, a plea is made for democracy, not domination, for DRG is an untested system which is bound to require evolution with experience.

As we enter the 215th year of the Medical Society of New Jersey, we are confronted with many changes. It is obvious to everyone that the manipulation of the OPEC states has brought about profound economic aberrations throughout the world, which threaten the way we live and function. There are other permutations that directly relate to our profession, e.g., those in *physician training* and *medical economics*, which appear to be on a collision course.

The basic problem that confronts us is the need to resolve whether we are producing too many physicians at a cost that further strains the total feasible outlay for health care. Is that outlay being distorted and dissipated by a lopsided distribution of physicians, geographically and functionally? The recent graduate medical education national advisory committee (GMENAC) focused on these very issues. The questions raised not only align medical economics with medical education, they raise the possibility of answers that would make *economics* the master of medical education and medical practice. That possibility exists even though a more conservative political force entered the national scene in January, 1981. Such matters as federal grants for medical schools and federal responsibility in health necessarily are not limited to any one political party.

American Medicine has seen many changes over the year; these changes are as important as any political change. For the sake of perspective, look at the trends in medical education and practice and at the needs that have shaped

them. Roughly, they can be divided into three historic stages:

(1) The first stage involved an urgent need for quality in training and in practice. In this country, medicine had a long and difficult time getting recognized as a scientific profession. Now we have arrived at a high state of the art of medical practice.

Americans have received a large share of the Nobel Prizes in physiology or medicine, but it is interesting to note that *no* United States-trained physician won this honor until 1934. The quality of medical education has made the United States a worldwide model and a sought-after mecca of training.

(2) The second stage of basic need and emphasis followed attainment of high-quality medical training and practice. This consisted of improving the supply and distribution of care through the mechanism of the medical education system. Until recent years, the concentration was on increasing the overall number of physicians and other health care support systems and personnel. In 1968, President Johnson claimed the nation was short 50,000 physicians. Pressure was placed on the medical schools to expand the size of their classes, accelerate their curriculum and produce more physicians. From this edict we gained 32 medical schools, making a total of 126, and a net increase of 100,000 active physicians for a total of 376,000 as of 1978. Hospital facilities were

*Inaugural address on the occasion of the author's induction into the presidency of the Medical Society of New Jersey. Presented before the House of Delegates, May 17, 1981, Secaucus, NJ.

“President Johnson’s deficiency of 50,000 physicians in 1968 has turned into a predicted surplus of 70,000 by 1990, including an oversupply in 18 specialties.”

“DRGs cannot remain static amidst changing medical practice, the impact of new technology or more refined abstracting systems.”

expanded apace through the Hill-Burton Act.

Now, there is a *surplus* of hospital beds and a numerical surplus of physicians, but we have a shortage of primary care physicians. President Johnson’s deficiency of 50,000 physicians in 1968 has turned into a predicted surplus of 70,000 by 1990, including an oversupply in 18 specialties. The long-range forecast for the year 2000 indicates there will be an excess of 145,000 physicians nationally. The data base for these statistics, which never have been verified, probably contains many duplications, retired physicians and non-clinicians.

(3) The third stage has to do with restraining health care costs. This principle could affect physician distribution. GMENAC stated “public and private reimbursement policies should be adjusted to emphasize ambulatory care services and training” and “encourage practice in underserved areas.” Economic constraints could adversely affect the quality of health care. Regardless of the results of the recent election it cannot be assumed that federal health regulations will diminish. The federal regulators may transfer responsibility to state regulators, a concept which is not a panacea to those of us practicing in New Jersey.

We are concerned for those who may be underserved by reason of inadequate health insurance benefits. To help the government act responsibly in health care expenditures, physicians in private practice will have to act realistically and responsibly in determining charges.

THE DRG PROJECT IN NEW JERSEY

The Diagnosis Related Group (DRG) approach has been tested for several years for various purposes. Through this experience critics have identified both strengths and weaknesses. One strength of the DRG system is its ability to classify patients into a manageable number of groups according to one measure of resource consumption, i.e., length of stay. Many believe that DRGs are the best available patient classification system which provides hospitals with an acceptable basis for measuring case mix. The system is an evolutionary concept which will change over time to reflect larger or different data bases, more refined abstracting systems, new diagnostic and therapeutic protocols and other variables.

Despite the advantages of DRGs, there are several concerns. DRGs cannot remain static amidst changing medical practice, the impact of new technology or more refined abstracting systems. Therefore, researchers continually will have to redefine and develop new DRGs by expanding on the concepts of the original work.

The basis for definition of the diagnosis related groups consisted entirely of discharge abstracts which often contained classification and coding errors, omission of diagnoses and variations which depended on the judgment of the

attending physician and the conventions of the individual coder. The impact of these errors on the groups is not known.

The strengths and limitations of DRGs will be identified through study of experimental applications. Being in their initial stages, the DRGs have not been tested sufficiently to allow a complete evaluation of the implications of their use. Recent experience has required the modification of the original DRGs because of limitations in their design. The current definition of DRGs may not be appropriate for national applications. The Department of Health presumes that hospital administrators can change a doctor’s practice patterns to comply with the DRG payment standards. Doctors strongly question attempts to standardize medical practice and they repudiate the notion of averages, focusing instead on the medical needs of the individual patient. Furthermore, informed patients will object to their physicians functioning as “efficiency experts” in matters pertaining to their health.

In my judgment, the present problems inherent in the DRG reimbursement system preclude any possibility of its successful implementation in New Jersey. Questionable methodology remains to be improved. Faulty data remain to be corrected. Efficient standards remain to be established. Vital information remains to be communicated. Hospital personnel remain to be educated. Physicians remain to be informed. Consumers remain to be involved. To close these vital gaps between concept and reality will take time—more time than the New Jersey Department of Health’s current DRG implementation schedule envisions.

To suggest that a plan so complex, with such far-reaching consequences, should be imposed before proper testing and evaluation speaks more for expediency than efficiency. To imply that problems of such magnitude can be resolved in the near future reflects more optimism than pragmatism. To infer that New Jersey hospitals are opposed to a concept which more closely links health care reimbursement to health care resources is incorrect. Yet hospitals—their trustees, their administrators, their physicians and many of their patients—are concerned that in reality the present DRG model will create more problems than it proposes to solve.

The State’s DRG model provides no uniform methodology to identify the primary diagnosis for which a patient is treated, and for which a hospital is reimbursed. The DRG model contains statistical aberrations in computational procedures which make accurate payment and cost comparison impossible. A major objective of the DRG concept is to compare the cost effectiveness of health care delivery among participating hospitals; the need to establish an accurate basis for such comparison is obvious. Given its present statistical weaknesses, however, the Department of Health’s DRG model makes valid comparisons impossible.

"Doctors strongly question attempts to standardize medical practice and they repudiate the notion of averages, focusing instead on the medical needs of the individual patient."

"To suggest that a plan so complex [as DRG], with such far-reaching consequences, should be imposed before proper testing and evaluation speaks more for expediency than efficiency."

The DRG model does not provide hospital administrators with timely information on which accurate decisions affecting the cost and quality of care can be based. Because DRG management reports proposed by the Department of Health will be based on two-year-old data when they arrive on a hospital administrator's desk, the information will be virtually meaningless and will make corrective action impossible. If DRG management reports are to hold meaning and serve to improve the quality and cost of health care, a method must be established to provide health care decision makers with more current data.

The DRG model offers no time or format to train hospital personnel—including physicians—in the mechanics of DRG reimbursement. There are no clearly defined standards and training aids, for the Department of Health assumes that hospitals and physicians will develop their own plan to unravel the complexities of DRG reimbursement. Such an approach will lead to widespread confusion, not universal comprehension. The DRG model assumes all physicians will adhere to prescribing patterns implicit in the system's

payment standards. Neither physicians nor patients are prepared to measure the efficacy of medical decisions against mathematical averages. A reimbursement system which related the payments a hospital receives to the resources it expends in the treatment of its patients is desirable. At present, there is no evidence to suggest that the Department of Health's DRG model will meet this objective.

In summary, we strongly suggest that necessary steps be taken to insure proper testing before implementation of this program.

—We need and want partnership and cooperation with medical colleges, hospitals, health insurers and other segments of society, including government, to meet the problems ahead.

—We want partnership *not* domination. Voluntary initiative and cooperation have solid, realistic answers to give now as in the past.

—We want the democratic way. That is a lesson which others might well learn—we hope it will not be the hard way.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Ceflor[®] (cefalor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceflor.

Contraindications: Ceflor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS. CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceflor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefalor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefalor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hemologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or on Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceflor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceflor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest[®] tablets but not with Tes-Tape[®] (Glucose Enzymatic Test Strip, USP, Lilly) (Usage in Pregnancy—Although no teratogenic or antifeetal effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.)

(Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.)

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceflor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceflor.⁷

Ceflor[®]

cefalor

Pulvules[®], 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefalor therapy are uncommon and are listed below: Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceflor (cefalor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients. Ceflor is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 1: 470, 1977.
3. Antimicrob. Agents Chemother., 13: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), 11: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Lilly

100081

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc. Carolina, Puerto Rico 00630.

Cerebral Thrombosis, Platelet Aggregation and Viral Infection*

MARTIN GELLER, M.D., Elmhurst, New York;
ARLEANE STIER, R.N., SISTER HELEN SOMOL, R.N.,
PORTIA B. WATSON, R.D., ANN MARIE NASO, B.T.,
MARVIN L. BIERENBAUM, M.D., Montclair;
ALAN I. FLEISCHMAN, Ph.D. (deceased)

The possible relationship of neurotropic viral infection to cerebrovascular accident was studied in 31 patients. An increased thrombotic tendency due to increased platelet aggregability was noted in 71 percent of a group of patients with this problem. No relationship was found with serum titers for herpes simplex, herpes zoster, E.B. virus or cytomegalic inclusion disease.

Pirkle and Carstens reported cases of unexpected sudden death in man associated with pulmonary platelet aggregates.¹ A similar finding of platelet aggregates in intramyocardial vessels of patients dying suddenly and unexpectedly of coronary artery disease was noted by Haerem.² Vreeken and Van Akens indicated that spontaneous *in vivo* platelet aggregation was considered to be the cause of recurrent venous thrombosis.³ Evidence exists linking the clinical state of a patient and the rapidity of *in vivo* platelet aggregation.⁴ In earlier work in our laboratory, we studied five patients with cerebral thrombosis and found a marked shortening of aggregation time which was one-fifth that of a clinically normal cohort. The normal subjects had neither overt clinical disease nor any risk factor known to be a precursor to cardiovascular disease. The finding was significant at the 99 percent level of confidence.⁵ Ten patients with neurotropic virus infections similarly were studied here and, although the shortened aggregation time was only a third of normal, it occurred in all patients affected.

Recent controversy has arisen over the precursor relationship of Coxsackie B virus to acute myocardial infarction.⁶ In view of this possible relationship and the earlier observations that patients with neurotropic viral infections showed shortened aggregation time, 31 patients with fresh cerebrovascular accidents were studied for serial viral titers and aggregation times. These studies form the basis of this report.

METHODS

Thirty-one adult patients with an established diagnosis of cerebrovascular accident (28 cerebral thrombosis and three hemorrhage), who were admitted in succession to a large community hospital neurological ward, formed the cohort for the study. The diagnosis of cerebrovascular accident was confirmed by spinal tap, electroencephalogram, computerized tomography scan where needed, and the usual history, physical examination and laboratory studies within 48 hours of admission. Thereupon, project staff obtained blood for serodiagnostic testing and serum lipids and accomplished a platelet aggregation determination by the Filtragometer technique. In earlier studies, results by the Filtragometer technique had been shown to be unrelated to age and sex but primarily affected by disease process and physiological state. In addition, acute neurological disorders such as subdural hematoma or cerebral hemorrhage had

*Dr. Geller is Director of Neurology at Mt. Sinai Hospital Services, City Hospital Center at Elmhurst, Elmhurst, New York. His co-authors are affiliated with the Atherosclerosis Research Group at St. Vincent's Hospital in Montclair. Dr. Bierenbaum also is with the New Jersey State Department of Health, as was Dr. Fleischman prior to his recent death. Correspondence may be directed to Dr. Bierenbaum at the Hospital, 48 Plymouth Street, Montclair, New Jersey 07042. This work was supported in part by a grant from the New Jersey State Department of Health and by a grant from The Charles Edison Fund. The opinions expressed in this paper are those of the authors and are not necessarily the official position of the New Jersey State Department of Health.

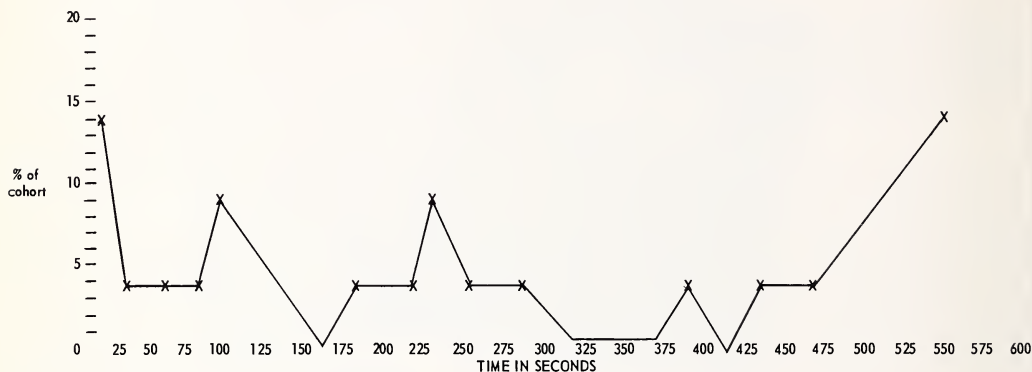
Table I
Participation Data

Patients studied	31
Patients lost to followup	10
Patients expired	4

Table II
Serum Lipids MG/DL

	1	2	P
Cholesterol	226	218	N.S.
HDL cholesterol	52.6	49.8	N.S.
Triglycerides	136	158	N.S.

Table III
Frequency Histogram of Aggregation Times
on Admission (21 Subjects with No ASA)



been associated with prolonged (over 300 seconds) aggregation times.

Just prior to discharge, but under no circumstances less than 15 days after the first sample, a second blood specimen was obtained for repeat serodiagnostic testing. As before, the blood specimen underwent:

1. Serodiagnostic testing for Herpes simplex, Cytomegalic inclusion disease, Herpes zoster and E.B. virus were done by the laboratory of the New Jersey State Department of Health. The E.B. virus titer was done by the ox-cell hemolysin test and the first three were complement fixation titers after the technique of Lennette *et al.*⁷
2. Lipid profile including serum cholesterol, cholesterol fraction and serum triglycerides.
3. Complete blood count with differential and platelets.

The patients received the usual management and when any inadvertently died (there were four deaths), the second blood specimen was obtained as closely to the time of demise as possible. At discharge, the neurological profile was noted and included in the subsequent data analysis. Patients started on drug therapy known to alter platelet aggregation, e.g., aspirin, dipyridamole, papaverine and others, were evaluated as a subset for this one parameter. This was done by the two-tailed paired-student "t" test with each subject serving as his own control for the paired observations.

Informed consent was obtained from all subjects in the study able to do so. For comatose or confused patients, next of kin had given informed consent.

RESULTS AND DISCUSSION

There were 31 patients admitted as the study cohort during the three-month period of observation from April 1, 1978 to June 30, 1978 (Table I). Of this group, ten subjects were lost to planned followup for various reasons. The most common

cause was death, there being four such events occurring before 15 days of hospitalization. Three of the four had autopsies confirming the diagnosis of cerebral thrombosis. Of the remaining six with no repeat studies, four left the hospital for other institutions, one signed out against medical advice to go home, and the last was transferred to another service. There were three patients with cerebral hemorrhage in the group, one of whom died. Earlier studies had shown that patients with hemorrhage generally had prolonged aggregation times—over 350 seconds. There were 21 subjects remaining on the neurology service for at least the prescribed 15 day period and they formed the basis for the remainder of the report.

Table II shows the results of the accumulated lipid data and, as can be seen, no significant changes occurred in any fraction during the study period. The same was true for the blood counts and platelet counts during observation. Of interest were the relatively low normal serum cholesterol and triglyceride levels found and the relatively normal HDL cholesterol fraction. This adds further confirmation to the frequently noted observation of no relationship of serum lipids to stroke incidence.

A frequency histogram of admission aggregation times is shown in Table III for the 21 subjects who had no aspirin or antiplatelet aggregating drugs during the ten-day period prior to admission. The vertical axis is the percent of the cohort and the horizontal axis is the aggregation time in seconds. Fifteen of the 21 subjects had aggregation times of 300 seconds or less and were at risk in this regard. In fact, ten had aggregation times of less than 200 seconds, placing them in the higher risk category in this regard and further solidifying the aggressive platelet-stroke relationship previously observed.

Table IV shows the results of the serodiagnostic testing on

Table IV
Virus Data with 2 Specimens

4 or greater HERPES 1 & 2		4 or greater HERPES ZOSTER		greater than 10 E. B. VIRUS		greater than 10	
1. 64	N C†	16	N C	—	N C	—	N C
2. 16	N C	8	N C	—	N C	32	N C
3. 16	N C	4	N C	—	N C	—	N C
4. 64	N C	8	N C	—	N C	—	32
5. 32	N C	—	N C	—	N C	64	32
6. 64	N C	8	—	—	N C	32	N C
7. 64	32	8	N C	—	N C	32	N C
8. 64	32	8	N C	—	N C	—	N C
9. 16	32	—	N C	—	N C	—	N C
10. 16	N C	—	—	—	N C	—	N C
11. 16	N C	4	N C	—	N C	—	N C
12. 16	8	4	8	—	N C	—	N C
13. 64	N C	16	8	—	N C	32	N C
14. 8	N C	8	N C	—	N C	—	N C
15. 32	N C	8	N C	—	N C	64	32
16. 32	N C	—	N C	—	N C	32	N C
17. 64	N C	8	N C	—	N C	32	N C
18.	—	—	—	—	N C	—	—
19.	—	—	—	—	N C	—	—
20.	—	—	—	—	N C	—	—

†N C = no change

the 20 subjects with two specimens available for analysis. Seventeen patients had significant herpes simplex titer, but no significant change on repeat. Thirteen subjects had a positive herpes zoster titer—a surprisingly high number for this cohort, but again there was no significant change on repeat study. Eight of the cohort had titers for cytomegalic inclusion disease and once again no changes of note were seen in titer. Finally, no one was found to have a significant titer for E.B. virus, which was a most surprising finding. Some questions have to be raised as to the validity of this result in view of the relatively high incidence of mononucleosis in the population of the Greater New York area.

CONCLUSIONS

The results of this study are of considerable interest in several ways and disappointing in others. On the negative side, the failure to find any relationship of either rising or decreasing titers of significance for the viral entities studied is somewhat disappointing, in view of earlier positive reports. However, it was not necessarily unexpected. It is possible that the basic thesis is entirely incorrect or that the wrong viral agents were studied. Another possibility is that the time frame for the repeat titers was too short and that another evaluation some two to four weeks later might have given positive data. Somewhat disturbing in evaluating the serological data was the failure to find any significant titer for E.B. virus in the 31 subjects of the study. Similar studies in the future must question the possible causes for this finding including the type of serological test done.

This cohort once again confirmed the failure to find a relationship between serum lipids and stroke. It also clearly showed that patients with cerebral thrombosis have a marked increase in thrombotic tendency with 71 percent of the untreated cohort having abnormal aggregation times. This finding suggests that potential benefit may be achieved by normalizing this parameter as early in the course of this

acute disease as possible. A study is now in progress utilizing prostaglandin E₁ for this purpose.

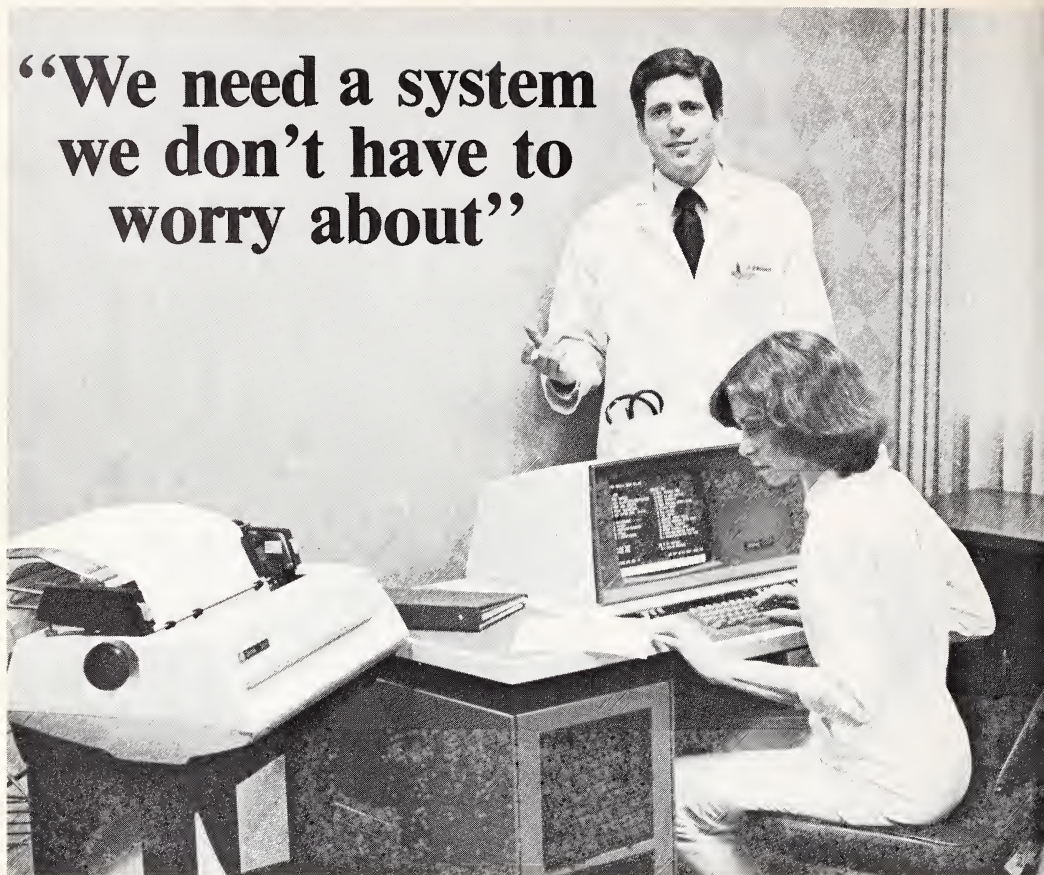
SUMMARY

In view of the relationship of neurotropic viral infection to increased platelet aggregability and the possible relationship to cerebrovascular accident, 31 patients with established diagnosis of stroke were studied. Parameters measured included platelet aggregability (by the Filtragemeter technique), serum lipids and sero-diagnostic tests for the more commonly found neurotropic virus particles. No relationship was found to stroke on two-week serial studies with complement fixation titers for herpes simplex, herpes zoster, cytomegalic inclusion disease, or E.B. virus. The possibilities of failure here are varied. Once again, no relationship between serum lipids and stroke was noted. However, it was clearly shown that patients with cerebral thrombosis have a marked thrombotic tendency with 71 percent of the cohort demonstrating abnormal aggregation times.

REFERENCES

1. Pirkle H, Carstens P: Pulmonary platelet aggregates associated with sudden death in man. *Science* 185:1062, 1973.
2. Haerem JW: Platelet aggregates in intramyocardial vessels of patients dying suddenly and unexpectedly of coronary artery disease. *Atherosclerosis* 15: 199, 1972.
3. Vreeken J, VanAken WE: Spontaneous aggregation of blood platelets as a cause of idiopathic thrombosis and recurrent painful toes and fingers. *Lancet* II: 1394, 1971.
4. Fleischman AI, Bierenbaum ML, Stier A: Effect of stress due to anticipated minor surgery upon *in vivo* platelet aggregation in humans. *J Human Stress* 2: 33-37, 1976.
5. Fleischman AI, Bierenbaum MD, Justice D, Stier A, Sullivan A: *In vivo* platelet function in acute myocardial infarction, acute cerebrovascular accidents and following surgery. *Thromb Res* 6: 205-207, 1975.
6. Nicholls AC, Thomas M: Cocksackie virus infection in acute myocardial infarction. *Lancet* 883-884, 1977.
7. Lennette EH, Schmidt NJ: *Diagnostic Procedures for Viral and Rickettsial Infections* (4th edition). New York, American Public Health Association, Inc., 1969, pp 52-58.

“We need a system we don’t have to worry about”



Dr. I. David Weisband, of the Regional Orthopedic Professional Association, is one of a growing number of physicians who’ve found Minicom’s Medical Practice Management System meets the unique needs of a medical practice.

Automatic preparation of statements, Medicare and insurance company forms; instantaneous, up-to-the-minute accounts receivable information, plus a variety of practice analysis reports.

“We treat patients, not computers,” Dr. Weisband says, “so we need a system we don’t have to worry about.”

And our Medical Practice Management System is just that. It

features reliable Xerox Diablo equipment and is backed by our policy of Unsurpassed Service—hardware, software, training, maintenance and system back-up, all from one reliable source.

“Our office manager and accounting firm investigated alternatives,” he continues, “and recommended the Minicom system as the best solution to our needs. I agree.”

So, before you invest in a computer system for your practice, take his advice. Look into our Medical Practice Management System. Drop the coupon in the mail, or give us a call...and ask about US!

I’d like more information on Minicom’s Medical Practice Management System.

Name

Address

City, State, Zip

Telephone (Area Code)



MINICOM

1415 E. Marlton Pike,
Cherry Hill, N.J. 08034
(609) 429-0600
(215) 925-6908

UNSURPASSED SERVICE

Distributors of Xerox business and professional computer systems.

Physician Careers and an Academic Health Science Center

THOMAS G. FOX, Ph.D., Piscataway*

ROBERT T. BLACKBURN, Ph.D., Ann Arbor, MI*

In 1977, CMDNJ-Rutgers Medical School signed a primary affiliation with Middlesex General Hospital and embarked on a large construction program to create an academic health center. The perceptions of nearby practicing physicians about this venture were sampled. The physicians were found to have deep roots in the area, educational backgrounds dominated by high prestige institutions, and attitudes and values independent of their specialty and place of training. The physicians were concerned with referral practices involving academic physicians while strongly supporting the development of the academic health center in their community.

In November, 1977, CMDNJ-Rutgers Medical School signed an affiliation agreement with Middlesex General Hospital, New Brunswick, New Jersey. The agreement made the hospital the school's primary teaching facility and committed the hospital and medical school to a more than 60 million dollar construction program to create an academic health science center. Speculation existed on the effects of having over 140 medical specialists, as well as a house staff and medical students, located in a community hospital which rapidly was expanding its facilities. To avoid the pitfalls which often have accompanied attempts by some medical schools to establish programs in a community, the CMDNJ-Rutgers Medical School conducted a study of area physicians to learn their feelings about the implications of a nearby fully developed medical school on their everyday professional life. The school wanted to know what problems they anticipated and if there was a relationship of anticipated problems to the physician's specialty, age and attitudes and values about academic medicine. The answers to these questions have shed some light on the immediate issues and anticipated problems of the CMDNJ-Rutgers Medical School. They also have illuminated aspects of physicians' careers and the values they hold.

THE SURVEY AND THE POPULATION

In the absence of any similar study, a questionnaire was developed from Spilerman's conceptualization of work history,¹ from Freidson's analysis of the medical profession,²

and from extended interviews and trial instruments with practicing physicians in Ann Arbor, Michigan and Central New Jersey. The Middlesex County Medical Society's endorsement of the study gave investigators access to the physician register. Two hundred sixty-one physicians completed all or part of a five-page instrument for a response rate of 48 percent.³ The respondents are representative of the total physician population in the county.

The typical Middlesex County physician is 48 years old, married (92 percent) and male (92 percent).⁴ His undergraduate education was at a selective private college or university. Forty percent graduated from research universities said to be among the 50 most selective in the country.⁵ Another 9.5 percent graduated from highly selective private liberal arts colleges.⁶ While the medical school he attended spans a wider range of prestige, 40 percent attended one of the eleven schools identified by Cole and Lipton as having the best reputations.⁷ Furthermore his roots, either by birth, schooling, residency or all three are in or not far from Middlesex County. A total of 64.8 percent did their residency in New York, New Jersey or Philadelphia. He is a specialist (less than ten percent see themselves as general practitioners)

*Dr. Fox is Associate Professor and Associate Dean, CMDNJ-Rutgers Medical School, Piscataway; Dr. Blackburn is Professor of Higher Education, Center for the Study of Higher Education, University of Michigan, Ann Arbor, Michigan 48105. Correspondence may be addressed to Dr. Fox at RMS, P.O. Box 101, Piscataway, NJ 08854.

"The typical Middlesex County physician is 48 years old, married (92 percent) and male (92 percent)."

"Sixty-seven percent of Middlesex County physicians make their referral decisions based on the reputation of specialist physicians."

and 72.6 percent are boarded in their specialty. He is on the staff at several hospitals.

RESULTS

(a) **Physician Referral Practices**—Sixty-seven percent of Middlesex County physicians make their referral decisions based on the reputation of specialist physicians. Another 20.2 percent make their selection on the basis of their combined knowledge of the physician and the hospital where he has his practice. Only 12.2 percent refer only because of a hospital's reputation. The intricacies of this important dimension of medical practice are physician centered and are one indication of the high value these physicians place on professional expertise (see section (b) below).

One hundred thirty physicians reported they had had one or more problems with the specialists to whom they have referred their patients. These problems included insufficient communication (28.5 percent), late reports (17.7 percent) and inadequate followups (26.2 percent). Twenty percent of the physicians felt a patient had received poor care and 28.8 percent have had at least one patient never return to their care.

If losing a patient to a specialist is a matter of high concern to practitioners when referrals are made 50 miles away, it is obvious area physicians foresee problems between themselves and medical school physicians. In fact, competition between faculty and community physicians was the number one future concern expressed by the respondents.

(b) **Physician types**—The predicted problems expressed by the practitioners are not common to all. Sub-groups of physicians hold quite different sets of values and these relate to their perceptions of the future. Some see the school's growth more optimistically than do others. A 25-item set of questions relating to the physicians' beliefs regarding the characteristics of an ideal medical center was analyzed using a Varimax Rotated Factor Matrix. The factor analysis sorted seven distinct value types. In rank order these values and examples of items sorted under each are:

(1) **Professional Separation**—Prompt referral of patients back to the original doctor with full information.

(2) **Status/Prestige**—Faculty reputation and leadership, quality of the school.

(3) **Research/Specialization**—Development of residency training programs, fellowship training, and research of the fulltime faculty.

(4) **Social Welfare**—Medical school responsiveness to community needs.

(5) **Support**—Availability of house staff, nurses, medical facilities to help care for their patients.

(6) **Convenience**—Closeness for care of their patients, nearby opportunities for continuing medical education.

(7) **Academic**—Desire to teach, do research, have a faculty appointment and supervise residents.

While the factors show some intercorrelation they are distinct and identify clusters of physicians. The clustering of values does not significantly correlate with medical specialty, age, location of practice or site of hospital privileges.

Table 1
Relative Value Strength

Rank Order of Importance		Mean Rating
1	Professional Separatism	3.986
2	Status/Prestige	3.756
3	Research/Specialization	3.451
4	Social Welfare	3.433
5	Support	3.285
6	Convenience	3.166
7	Academic	2.655

Rating Scale

- 5 - Critical/essential
- 4 - Very important
- 3 - Important
- 2 - Of some concern
- 1 - Not really that important

Table I shows that of all seven value groups, academic values receive the lowest rating. Furthermore, those area physicians who highly value academic medicine are personally five times more interested in teaching than they are in doing research. Status and prestige of the medical school ranked second in their priorities. Because it is research which contributes most to a medical school's national reputation, this low rating for research and high rating for status and prestige has the potential to introduce conflicts if the town physicians do not appreciate the medical school's need to recruit faculty who are active researchers.

(c) **Impact of the School**—As can be seen from Table II, the number of physicians who look positively to the advent of the medical school far outnumber those who harbor forebodings. Over half perceive only positive outcomes. One-fifth expect to be essentially unaffected. Only four percent express negative consequences, a number appreciably less than predicted and one which is apparently far out of proportion to the noise level these prophets have created. The dominant view is that the medical school will fit well with community physician career plans and desires.

"... of all seven value groups, academic values receive the lowest rating."

“... the number of physicians who look positively to the advent of the medical school far outnumber those who harbor forebodings.”

“The study clearly shows the significance of the referral process in generating and maintaining acceptance and cooperation.”

Table 2
Perceived Impact of Medical School
on Physicians' Careers

Career Fit/Impact	N	%
Perfect; positive benefit	77	35.1
Good for teaching	20	9.1
Good for consultation	14	6.4
No relationship; no impact	44	20.1
See no problems	23	10.5
Conditional; "it depends on"*	18	8.2
Bad relationship; bad impact	9	4.1
Other (obscure)	14	6.4
Totals	219	99.9

Msng = 23

*A wide assortment of "if" statements are contained in this category. E.g., impact will be positive "if it develops my specialty," "if I can teach," "if it is concerned about all in the community," "if . . ."

DISCUSSION AND SUMMARY

The study shows strong value concordance between the community and faculty physicians. While there are differences in priorities, their magnitude does not preclude satisfactory blending within the total mission of an academic health science center. The study clearly shows the significance of the referral process in generating and maintaining acceptance and cooperation. In general, area physicians want to be part of the education process and look with favor on the school's development in their midst. The low levels of concern by practicing physicians was surprising.

There are constructive acts all parties can engage in to

mitigate potential problems. The medical faculty can be made aware of the talents of their professional peers. The community physicians need to be aware of aggregate views as a balance to the loudest voices. Ideally, the referral process should work both ways. Clinical faculty appointments can be used to create social as well as professional linkages. As the center matures, what is learned can be broadly dispensed through continuing education to assure that changes in treatment modalities do not come as surprises. The community physicians value the increased access to expert consultations and it will be the responsibility of the faculty to see that these are handled in a way which does not squander the large reservoir of goodwill which currently exists.

A followup study is planned for one year after the construction program has been completed. That study will measure the school's success in alleviating the initial apprehensions of community physicians and in blending the values of community and faculty physicians while creating an academic health science center.

NOTES AND REFERENCES

1. Spilerman S: Careers, labor market structure, and sociometric achievement. *Am J Sociol* 83:551-593, 1977
2. Freidson E: *Profession of Medicine*. New York, Harper and Row, 1970
3. The effective response rate exceeded 50 percent as 27 questionnaires were returned as undeliverable.
4. Given the predominance of men, the masculine gender of pronouns is used to simplify the diction.
5. Carnegie Council on Higher Education: *A Classification of Institutions of Higher Education*. Berkeley, California, 1976
6. Ibid.
7. Cole J, Lipton J: The reputations of American medical schools. *Soc Forces* 55:662-684, 1977



Two convenient dosage forms:
100 mg (white) and 300 mg (peach)
Scored Tablets



Tablets imprinted with brand name to
assist in tablet identification.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Lipoma of the True Pelvis*

GEORGE CHIROVSKY, M.D., DAVID LAWRENCE, M.D.,
JEFFERSON BASTIDAS, M.D., Livingston

A 29-year-old female had urinary complaints and a right gluteal mass. After thorough evaluation, a nine-pound pelvic lipoma was excised and the patient did well. One must be concerned by the similarity in presentation between this lipoma and those of the retroperitoneal space, which have 50 percent recurrence and 30 percent malignant degeneration rates. This patient, as well as other patients with large lipomas in "blind spaces," should be followed for extended periods to ensure adequate treatment.

Large retroperitoneal lipomas have been well documented in medical literature as to their presentation and behavior. To the author's knowledge, large lipomas of the pelvis, however, have not been reported. We present such a lipoma with a comparison of it to the well-known retroperitoneal lipoma.

CASE REPORT

On December 11, 1978, a 29-year-old woman was admitted to Saint Barnabas Medical Center for evaluation of a right gluteal mass.

The patient had intermittent urinary incontinence for ten months. This had been accompanied by slowly increasing nocturia, hesitance, poor stream and frequency (10 to 20 times a day) for five months. Two weeks prior to admission to the hospital, she entered another hospital because of urinary retention. Cystoscopy revealed the bladder to be elevated anteriorly and compressed extrinsically from below and the right side. An intravenous pyelogram showed elevation of the entire bladder by a pelvic mass (Figures 1A and 1B). There was no evidence of gourd-shaped bladder to suggest pelvic lipomatosis. She improved on catheter drainage for 24 hours, was discharged, did well for one week and then was admitted to Saint Barnabas Medical Center for further evaluation.

On examination, she appeared as a healthy young woman in no acute distress. A non-tender, grapefruit-sized, movable

mass was noted in the right buttock. This mass was not noted at the earlier admission by her previous doctor. It was felt easily through the rectum and vagina and was noted to be displacing them to the left. All laboratory values were normal. Chest x-ray was normal; barium enema showed a large pelvic mass causing displacement and compression of the rectosigmoid (Figure 2). A pelvic ultrasound study showed normal pelvic organs; the mass was entirely below the peritoneum (Figure 3). Because of the possibility of a malignant growth an angiogram was performed (Figure 4). This was interpreted as showing a lipomatous, avascular, right pelvic mass. A liposarcoma, however, could not be excluded.

OPERATION

A mechanical and antibacterial bowel preparation before exploratory surgery was prescribed. At operation the patient was first explored through a Pfannenstiel incision to assess the extent of the lesion and to secure access to the large pelvic vessels in the event of injury during removal. The mass which was soft and movable was entirely below the pelvic peritoneum and filled the entire true pelvis. The bladder was elevated and the ureters were adjacent to the anterior

*From the Departments of Surgery and Radiology, Saint Barnabas Medical Center, Livingston, New Jersey, where Dr. Chirovsky is a resident in surgery and Drs. Lawrence (surgery) and Bastidas (radiology) are members of the staff. Correspondence may be addressed to Dr. Chirovsky at the Medical Center.



Figure 1-A—Scout film of the abdomen demonstrating a well-demarcated radiolucent right pelvic mass.



Figure 1-B—Fifteen-minute I.V.P. study outlining marked displacement and compression of the bladder caused by the lipoid pelvic mass. No obstructive uropathy is noted.



Figure 2—Barium-enema examination demonstrating severe extrinsic pressure effect and displacement of the rectosigmoid colon.

abdominal wall. There was no evidence of malignant spread. The mass then was approached posteriorly. A curvilinear incision was made vertically over the right buttock. As the dissection continued the mass was easily shelled out from the surrounding structures. This was further evidence against pelvic lipomatosis. The mass filled the pelvic cavity and the ischiorectal space by extension. The entire mass was quite avascular and was removed intact. Suction drains were placed in the right ischiorectal space. Prior to the closure of the abdomen, it was noted that the displaced pelvic structures had returned to their normal position. Pathologic examination revealed a benign lipoma weighing 3800 gm. Postoperatively, the patient did well, and was able to void normally. She was discharged on the eighth postoperative day. Followup has revealed no abnormalities physically or functionally for two years.

DISCUSSION

An extensive search of the medical literature has failed to produce an example of such a large benign lipoma of the pelvis as the one discussed above. The authors believe that this is not because such an event has never occurred but more likely because its significance was not noted.

Because of the nature of the retroperitoneal space, lipomas that arise there can become quite large before causing symptoms. They appear to be the most common benign retroperitoneal tumors. They may originate in the perineal fat, mesenteric fat, or in any other adipose tissue in the retroperitoneum. Their growth is slow and symptoms usually arise from pressure effects on adjacent organs.⁴ Through this compression on adjacent organs, they occasionally lead to a slow death from cachexia, starvation, ileus or uremia. On rare occasions, lipomas of the retroperitoneum have been known to grow at a very rapid rate.³ Rhamy noted that they have a recurrence rate of approximately 50 percent.⁵ Fum-merle and Ritter contend that ten to 35 percent of retro-



Figure 3—Transverse and longitudinal ultrasound scans demonstrate a large echogenic mass (M) producing severe displacement to the bladder and uterus (U).

peritoneal lipomas are inoperable. Half of those operated recur repeatedly in a short period of time and the overall incidence of malignant degeneration is about 30 percent.²

At most sites the lipoma is a perfectly innocent tumor which rarely recurs after complete removal. The retroperitoneal lipoma, however, as noted above, is quite distinctive as to its rate of growth, size attained, degree of spread and histologic and clinical features. It is generally accepted and clearly defined by Altemeier and Alexander that "the anatomy of the retroperitoneal space includes the area between the diaphragm superiorly and the brim of the true pelvis inferiorly; between the posterior parietal peritoneum anteriorly and the transversalis fascia and muscles of the abdominal wall posteriorly."¹



Figure 4—Pelvic arteriogram outlining marked displacement of the right pelvic vessels especially the right uterine and vesical branches. No neovascularity or tumor encasement is noted.

The lipoma found in this patient then, clearly, is one outside of the retroperitoneal space as defined. However, due to its mode of presentation, large size and degree of spread, it would appear to be acting much like a lipoma of the retroperitoneal space. For this reason, close followup has been maintained on the patient, who has had no recurrence to date.

CONCLUSION

It is the opinion of the authors that lipomas of the pelvis, or any other "blind space" in the human body, should be closely followed for recurrence and degeneration. Lipomas of the retroperitoneal space are prone to these problems. Since lipoma of the pelvis may act more like retroperitoneal tumors than lipomas of the periphery, the patient should be followed carefully.

BIBLIOGRAPHY

1. Altemier WA, Alexander JW: Retroperitoneal abscess. *Arch Surg* 83:512, 1961.
2. Fummerle F, Ritter G: Giant retroperitoneal lipomas. *German Medicine Monthly* 13:331, July 1968.
3. Garipey LB: Retroperitoneal lipomata. *J Mich Med Soc* 60:343, 1950.
4. McCarthy MP: A large retroperitoneal lipoma. *J Urol* 118:478, 1977.
5. Rhamy RK: Retroperitoneal tumors, in Glenn JF, Boyce W (eds): *Urologic Surgery* 2nd ed. New York, Harper and Row, 1975, p. 862.

June Open Enrollment!!! Doctors: There's still time to sign up for group major medical!

**BROAD COVERAGE FOR MEMBERS
PARTICIPATING IN BASIC
GROUP BLUECROSS/BLUESHIELD PROGRAMS**

Officially Endorsed by the Medical Society of New Jersey

For More Information Contact:

DONALD F. SMITH & ASSOCIATES

One Airport Place, Route 206 North, PO Box 2197 Princeton, New Jersey 08540 (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross / Blue Shield

The Bone Scan in the Blastic Variant of Multiple Myeloma*

LOUIS S. ZEIGER, M.D. and KOSON KURODA, M.D., Camden

A 52-year-old woman presented with back pain and the x-ray appearance of diffuse blastic lesions and one large lytic lesion in the sacrum. Bone scan showed minimal diffuse increased uptake and a large "cold" lesion at the site of the lytic lesion on x-ray. The patient had typical multiple myeloma with a monoclonal gammopathy.

The presentation of multiple myeloma as a predominantly diffuse blastic bone disease is most unusual. Such a case is reported in which the level of osteoblastic activity as seen on a ^{99}Tc -MDP bone scan was minimal with respect to the level of calcification seen on x-rays. This subtle increased uptake throughout the axial skeleton, except for a cold lesion in the right hemisacrum where a lytic lesion was present on sacral x-ray tomography, would be expected in multiple myeloma, but not in osteoblastic metastases, the main differential point in diagnosis.

CASE REPORT

The patient was a 52-year-old woman with a progressive history of headaches, myalgia, and bone pain of one year duration. X-rays of the cervical spine, lumbar spine, and chest showed multiple and diffuse blastic lesions throughout the entire axial skeleton and a lytic lesion in the right half of the sacrum (Figure 1). Whole body scan three hours after injection of ^{99}Tc -methylene diphosphonate demonstrated subtle increased uptake throughout the entire axial skeleton relative to renal uptake. There were no focal lesions with increased uptake, but an apparent *cold* lesion was noted in the right hemi-sacrum (Figure 2). The serum alkaline phosphatase level was 94 mu (85 top normal). The serum protein

electrophoresis showed an elevated protein level of 8.5 gm/dl (6 to 8 normal range) with a gamma spike of 2.8 gm/dl (0.7-1.7 normal range). This patient, therefore, had a monoclonal gammopathy consistent with multiple myeloma. This diagnosis was established with an open biopsy of the lytic lesion of the sacrum.

Negative laboratory studies of significance during the admission were: parathyroid hormone level of 212 PG/ML associated with a serum Ca (total) of 9.4 mg/dl; T3 resin uptake of 35.2 percent (normal 35 to 45%), T4 of 9.0/mg/dl (normal 3.5 to 13.0), thyroid uptake of 23 percent (normal 10 to 35%), and CEA 0.4 mg/dl (normal 2.5). A ^{123}I Thyroid Scan and a liver scan were normal. X-ray mammography was also negative bilaterally.

DISCUSSION

The typical case of multiple myeloma presents with osteolytic lesions which do not significantly concentrate the

*From the Cooper Medical Center, Camden where Dr. Zeiger is Chief, Division of Nuclear Medicine, Department of Diagnostic Radiology and Nuclear Medicine, and Clinical Assistant Professor of Radiology, Rutgers Medical School-CMDNJ. Dr. Kuroda is Chairman, Department of Diagnostic Radiology and Nuclear Medicine and Clinical Professor of Radiology, Rutgers Medical School-CMDNJ. They may be addressed at Cooper Medical Center, One Cooper Plaza, Camden, NJ 08103.



Figure 1—Anterior-Posterior x-ray of the lumbar spine shows diffuse blastic lesions throughout the axial skeleton and a lytic lesion in the right hemi-sacrum.

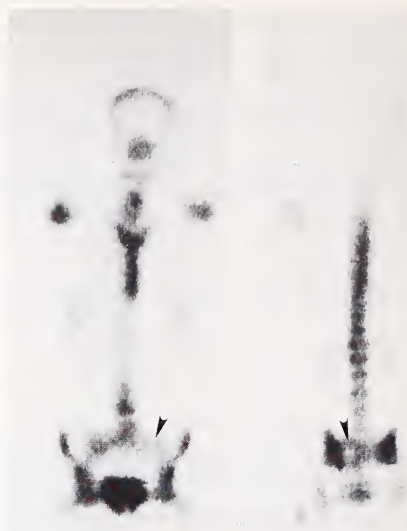


Figure 2—⁹⁹Tc-MDP bone scan shows diffuse increased uptake throughout the axial skeleton. In addition a cold lesion is seen in the right hemi-sacrum.

phosphate type of radionuclide agent unless infraction has occurred. And according to Hubner¹, only 53 percent of radiographically identified lesions show any increased uptake on bone scans. Our patient presented with the usual combined findings of a biochemical and histological diagnosis of multiple myeloma and minimal ⁹⁹Tc-MDP bone uptake but with an atypical predominately osteoblastic radiographic appearance. The x-ray survey demonstrated diffuse blastic lesions throughout the axial skeleton with a lytic lesion in the sacrum.

It is apparent from the articles by Charkes² and Hubner¹ that the bone lesion of myeloma, whether radiographically osteolytic or osteoblastic in appearance, does not elicit the rate of nuclear assessed osteoblastic activity from bone as do metastatic lesions. When diffuse blastic metastases from breast carcinoma or lymphoma are present radiographically, the bone scan is typically grossly abnormal with increased uptake. The bone scan in our case showed findings consistent with multiple myeloma with only minimally increased uptake in the axial skeleton and a "cold" lesion where the lytic lesion was seen on x-ray. This degree of uptake, coupled with the

absence of any other detectable primary or metastatic malignant activity, strongly suggested that the osteoblastic lesions did not represent metastases.

The possibility of an abnormal parathyroid or thyroid process producing diffuse sclerotic lesions also was ruled out by the appropriate negative laboratory studies.

And finally, in our case, the diagnosis of multiple myeloma was established by serum protein electrophoresis and an open bone biopsy.

It is proposed that the combination of osteoblastic lesions of the axial skeleton by x-ray and a bone scan with discrepant minimal uptake, as in our patient, suggests the diagnosis of multiple myeloma rather than diffuse metastases.

REFERENCES

1. Hubner KF, Gould AA, Hayes RL, Doggenburg JK, Solomon A: The use of rare-earth radionuclides and other bone seekers in the evaluation of bone lesions in patients with multiple myeloma or solitary plasma cytoma. *Radiol* 125:171-176, (October) 1977.
2. Charkes ND, Durant J, Barry WE: Bone pain in multiple myeloma. *Arch Intern Med* 130:410-415, (July) 1972.

"... the bone lesion of myeloma, whether radiographically osteolytic or osteoblastic in appearance, does not elicit the rate of nuclear assessed osteoblastic activity from bone as do metastatic lesions."

"The typical case of multiple myeloma presents with osteolytic lesions which do not significantly concentrate the phosphate type of radionuclide agent ..."

Sister Mary Joseph Node— A Clue to Internal Malignancy*

EDWARD F. SCHNIPPER, M.D., MICHAEL J. NISSENBLATT, M.D.,
MELVIN SCHWARTZ, M.D., and SHELLY L. LUDWIG, M.D., Piscataway

Tumors of the umbilicus are uncommon. One-third of such lesions are metastatic and can point to a diagnosis of disseminated malignancy. We present a case of colon carcinoma presenting as an umbilical mass. This is known as the Sister Mary Joseph Node.

Umbilical nodules are caused by metastatic carcinoma, endometriosis and primary carcinoma with nearly equal frequency.¹ As a vestigial organ, however, the umbilicus is often ignored during the physical examination. Since an umbilical mass may be a subtle clinical presentation of visceral neoplasia, we emphasize the need to examine the umbilicus during the physical examination as we would inspect any other organ. A malignancy of the umbilicus is known as a Sister Mary Joseph Node.

CASE HISTORY

A 52-year-old woman presented with a three to four-week history of an umbilical mass. She had been in her usual state of health when she awakened one morning with a tender lump at her umbilicus. Deep abdominal pain was absent. There had been no trauma to the umbilicus. There was neither fever nor chills. There were no constitutional symptoms; in particular, her appetite was excellent and there had been no weight loss. There had been no change in bowel habits or in the character of stools.

Past medical history was significant for removal of a sarcoma from her left arm 15 years before. No recurrence had developed. There was a long time history of menorrhagia without any recent change. Her mother had died of carcinoma of the stomach.

On physical examination vital signs were normal. The general examination was unremarkable and positive physical

findings were limited to the umbilicus where there was an indurated violaceous erythematous tender mass measuring 4x5 cm. superficially and 7x9 cm. subcutaneously (see Figure 1). The mass was not adherent to intra-abdominal organs.

The initial clinical impression was that of an abscess. An aspiration of the mass demonstrated no pus. However, the patient was placed on dicloxacillin for four days with some improvement. Additional aspiration found inflammatory cells without neoplasia. Needle biopsy demonstrated poorly differentiated adenocarcinoma.

In the evaluation that followed, an "apple core" lesion of the rectosigmoid colon was demonstrated on barium enema. Resections of the umbilical mass and sigmoid lesions were performed simultaneously. The sigmoid carcinoma penetrated through the serosa. Lymph nodes were positive, and the peritoneum was studded with additional metastases. The umbilical mass was found to be discontinuous from the bowel primary. The liver was free of metastases.

The patient was placed on a regimen of 5-fluorouracil (5-FU) and currently remains symptom free two months following surgery.

*From the Departments of Medicine, Division of Hematology/Oncology (Drs. Schnipper, Nissenblatt, Schwartz), and Gastroenterology (Dr. Ludwig), CMDNJ-Rutgers Medical School, Piscataway, NJ. Correspondence may be addressed to Michael J. Nissenblatt, M.D., Division of Hematology/Oncology, Department of Medicine, Middlesex General Hospital, 180 Somerset St., New Brunswick, New Jersey 08901.



DISCUSSION

The association of umbilical tumors with neoplasia was first reported in the mid 19th century. In the 1890's Sister Mary Joseph, who was the chief surgical assistant for Dr. William Mayo at St. Mary's Hospital in Rochester, Minnesota, focused attention on the phenomenon. Appropriate recognition was given to her when Sir Hamilton Bailey recommended that such umbilical tumors be called a Sister Mary Joseph Node.^{1,2}

A MEDLARS search of the American medical literature indicates that fewer than ten cases of Sister Mary Joseph Nodes have been reported in the last ten years. Steck and Helwig found that ten percent of metastases of carcinoma to the abdominal wall involved the umbilicus, suggesting that this may be a preferred, but ignored, site of spread.⁴ These nodes may be subtle, and are usually less than five cm. in diameter. They are typically irregular in shape, firm to palpation and are usually painless unless ulceration of the soft tissue occurs. On occasion an ulcerated nodule may exude blood, mucous or serous fluid. Superinfection is unusual. Most importantly, since these nodules may represent metastatic disease, they are signs of advanced or systemic carcinomatosis.

Among the cancers causing Sister Mary Joseph Nodes, adenocarcinoma is the most common histologic type. Barrow (1967) studied 677 patients with umbilical carcinoma, 202 (29.8 percent) of which were metastatic in origin. In nearly 30 percent of persons with these metastases, the

primary carcinoma could not be found despite intensive investigation. Among the remaining 70 percent of persons stomach, ovarian, pancreatic and colorectal cancers were the most common causes in decreasing frequencies. Other investigators have had similar findings.^{3,8} However, other primary sites have been described including breast, liver, small bowel and multiple myeloma.⁹ The vast majority of primary tumors originate below the diaphragm.^{1,3-8}

Neoplastic dissemination to the umbilicus may occur through several routes.⁵ The umbilicus is composed of a single vein, two arteries and lymphatics during embryogenesis and fetal life. These all remain as vestigial structures after birth. Dissemination of cancer to the umbilicus may occur by (1) translymphatic spread, (2) regurgitation of cells from the portal system, retrograde through the umbilical vein or (3) via transserosal peritoneal implantation. In view of the transserosal growth of this patient's tumor, as well as the presence of positive lymph nodes, it is likely that either of the latter two mechanisms is operative in this patient.

This patient presented with an obvious neoplasm in the umbilicus. There may be occasion when an umbilical presentation of neoplasia is more subtle since pain and erythema is uncommon in these metastases. It is because intra-abdominal neoplasms may present with umbilical metastases that we urge wider recognition of this presentation and encourage regular examination of this organ in search of the Sister Mary Joseph Node.

SUMMARY

We reviewed a case of colon carcinoma presenting as an umbilical mass. Umbilical masses are evenly distributed between primary tumors of the umbilicus, endometriosis and metastatic lesions. The most common site of origin of metastatic lesions is within the abdomen. In view of this association we present this case to encourage the wider recognition of the Sister Mary Joseph Node.

REFERENCES

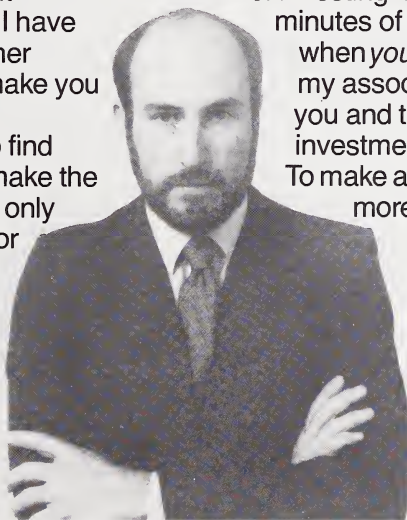
1. Barrow MV: Metastatic tumors of the umbilicus. *J Chron Dis* 19:1113-1117, 1966.
2. Bailey H: *Demonstrations of Physical Signs in Clinical Surgery*, 11th ed. Baltimore, Williams and Wilkins, 1949, p. 227.
3. Key JD, Sheppard DAE, Walters W: Sister Mary Joseph's nodule and its relationship to diagnosis of carcinoma of the umbilicus. *Minn Med* 561-566, 1976.
4. Steck WD, Helwig EB: Tumors of the umbilicus. *Cancer* 18:907-915, 1965.
5. Charoenkul U, Delcampo A, Derby A, Hodgson WBJ, McElhinney AJ: Tumors of the umbilicus. *Mt. Sinai J Med* 44:257-262, 1977.
6. O'Leary JL, O'Leary JA: Carcinoma of the umbilicus. *Am J Obstet Gynecol* 89:136-137, 1964.
7. Horn JJ, Fred HL, Lane M, et al: Umbilical metastases. *Arch Intern Med* 114:799-802, 1964.
8. Scarpa FJ, Diheen JP, Boltax RS: Visceral neoplasia presenting at the umbilicus. *J Surg Oncol* 11:351-359, 1979.
9. Bank H and Liberman SI: Sister Joseph's nodule and malignant ascites in multiple myeloma. *N Engl J Med* 284:676, 1971.

MY SUNBELT CONDOMINIUMS CAN SAVE YOU TAXES AS SOON AS YOU BUY ONE, SHELTER YOUR INCOME WHILE YOU OWN IT, AND EARN YOU MOST ATTRACTIVE CAPITAL GAINS WHEN YOU SELL.

Now you can take advantage of what years of success in investment real estate have taught me—free.

It doesn't cost you a penny to learn about the best sunbelt condominium investments I have found for you and many other professionals. And it can make you a lot of money.

I travel the country to find condominiums I think will make the wisest investments. Select only the very best apartments for you to own. Write a report that covers all the questions good investors ask—the construction, the neighborhood, the view, and the appreciation potential. And, of course, the tax angles.



Before I recommend any condominium to you, I invest in at least one of its apartments for myself.

I'd like to tell you about my way of investing. It will take only a few minutes of your time, where and when you say, to show you what my associates and I can do for you and the health of your investment portfolio.

To make an appointment, or for more information, complete and mail the coupon below. Or, better still, call me right now at:

(201) 962-6300

Ken Gluckman
President
Skyline Associates, Inc.
72 Hickory Road
Ringwood, New Jersey 07456

FILL IN, MAIL NOW!

J-1

- ☐ Please call me to set up an appointment at no cost or obligation.
☐ Please send me more information.

Name _____
(Please print or type)
Address _____
City _____ State _____ Zip _____
Telephone () _____ () _____
office home



Skyline Associates, Inc.
72 Hickory Road, Ringwood, New Jersey 07456 • (201) 962-6300

Christian Health Care Center

... since 1911

Wyckoff, New Jersey

07481

301 Sicomac Avenue • (201) 427-2816

A private facility which offers the following services:

INPATIENT PSYCHIATRIC SERVICE

- 81 bed facility for continued care (primarily psychiatric-geriatric)
- 14 bed short term unit for women over 18 years of age

OUTPATIENT PSYCHIATRIC SERVICE

- Serving all ages with psychiatric and counselling services
- Continuing care and supervision for patients

Fully accredited by Joint Commission of the Accreditation of Hospitals.

Able to accept either voluntary or involuntary patients.

For further information regarding admission, write or call Admission Office



Status Report on New Jersey Health Maintenance Organizations (HMOs) – 1980

SHELLEY MERIWEATHER FERRAND, M.H.S.A., Lawrenceville*

During 1980, the HMOs in New Jersey exhibited varying degrees of growth. Most HMOs showed the ability successfully to penetrate the market, while some found it difficult to adhere to sound management practices and appropriate utilization. Actual HMO development has taken a cautious pace. Many regions, however, have the potential to support viable HMO plans.

One of the major responsibilities of the Foundation is continuously to study the developments and activities of Health Maintenance Organizations (HMOs), nationally and, more importantly, in the State of New Jersey. The Medical Society of New Jersey and the New Jersey Association of Osteopathic Physicians and Surgeons consistently have given their support to the Foundation's activities of objectively analyzing and reporting on HMO activities, not only in response to organized requests from physician groups, but also from requests of the individual physician constituency. This report is an illustration of our endeavors in the area of HMO assessment. In an effort to bring both the Medical Society and Osteopathic Association up-to-date on New Jersey HMO activity, as well as in an effort to draw some observations and conclusions about HMO activity in the State over the past year, the following is an excerpt from the first in a series of annual reports on the status of HMOs in New Jersey.

Several sources were used in compiling the report. Among them were the New Jersey State Health Department, Division of Alternative Health Systems, formal and informal interviews and meetings with management staff of the HMOs and data compiled on a periodic basis by the U.S. Department of Health and Human Services, Office of Health Maintenance Organizations. In addition, site visits have been made to some of the HMOs, in an effort to view actual operations and to speak with staff members. The time frame ending the report is December 31, 1980, unless otherwise

indicated. Comments and questions may be directed to the New Jersey Foundation. We appreciate any responses.

INTRODUCTION

National HMO enrollment increased 12 percent from mid-1979 to mid-1980. During the same time period, there was a ten percent increase in the number of operational plans. Total national enrollment reached 9,183,397 by the middle of last year (1980), up by more than one million over the levels reported by the federal HMO office a year earlier. This growth rate, which occurred while a worsening economy affected many other key industries, is slightly higher than that of the previous year. HMO enrollment in New Jersey, however, has taken a much brisker pace than the national figures, although in actual numbers enrollment is relatively small.

Enrollment in New Jersey Health Maintenance Organizations (HMOs) has increased 74 percent over the past year and a half.¹ As of December 1980, there were 158,887 enrollees in nine operating HMOs. Among these New Jersey plans are two Group, three Staff and four Individual Practice

*Ms. Meriweather Ferrand is Assistant Director, New Jersey Foundation for Health Care Evaluation. She may be addressed at the Foundation, Two Princess Road, Lawrenceville, NJ 08648.

¹An HMO is an organization that delivers comprehensive health services to voluntarily enrolled members in return for a fixed, prepaid fee.

“... 96 percent of the HMO members in New Jersey are enrolled through their employers. These include trust funds, private employer groups and government plans.”

“... while HMOs are introducing competition to the ... health care industry that serves the working population ... they are not addressing the needs of the aged or the poor.”

Association (IPA) models.²

The service areas for these operating plans are:

1. Blue Cross/Blue Shield HMO
- (a) Mercer Regional Medical Group: Greater Trenton Area
- (b) Southern Inter-County Medical Associates (SIMA): Salem and Cumberland Counties (except Vineland);
2. CoMED: Morris, Somerset (except the Watchung Peninsula), and parts of Passaic, Sussex, Warren Counties;
3. Crossroads Health Plan: Essex County;
4. Cumberland Regional Health Plan: Greater Vineland Area;
5. Health Care Plan of New Jersey: Camden County and parts of Burlington and Gloucester Counties;
6. HIP of Greater New Jersey: Hudson County and part of Bergen County;
7. Rutgers Community Health Plan: Middlesex, Somerset and parts of Union, Mercer and Monmouth Counties;
8. Southshore Health Plan: Atlantic County and the northern part of Cape May.

At this time, two other HMOs are developing with federal grant assistance. One of these, HealthWays, projects that it will begin operations by the Spring of 1981 as a federally qualified IPA model HMO in Middlesex and Union Counties. The other, Valley Health Plan, is studying the feasibility of HMO operations in the Passaic County Area.

Another study funded by the Bergen County Medical Society indicated the feasibility of an IPA model HMO in Bergen County. However, during the fall of 1980, the Medical Society membership voted as follows: “The membership of the Bergen County Medical Society, having considered the matter carefully, does not desire to form or participate in an HMO/IPA. Consequently, there shall be no further consideration of this form of medical practice by the Society.”

The HMOs in New Jersey exhibit a wide range of characteristics, including different benefit packages and number of years in operation. Care must be taken when reviewing the report to consider these differences when comparing plans.

There are numerous issues that present an ongoing challenge to the HMO industry. HMOs are faced with fiscal and management difficulties arising in part from market factors which beset all small business ventures, as well as certain problems unique to HMOs. The HMO industry has grown faster than the available supply of experienced HMO managers. This disparity between the supply of management expertise and the demand for it is common to relatively new ventures. In addition, members of some HMO boards of directors have lacked the expertise needed effectively to set HMO policy and oversee operations.

This report will focus on specific management issues that impact on the ability of New Jersey HMOs to operate successfully in serving residents of the State. The report will

address various issues in general terms, encompassing all HMOs in the State. The intention of this report is not to cast judgment on the degree of success of the New Jersey HMO movement or any individual HMOs. However, it is the intent of this report to present the facts and point out areas that have potential impact, positive or negative, on HMO development and operations.

THE MARKET AND HMO ENROLLMENT

(a) **Private Employer Groups**—An HMO markets to employees who reside within its designated service area. In fact 96 percent of the HMO members in New Jersey are enrolled through their employers. These include trust funds, private employer groups and government plans.

In most cases, when employers offer the HMO option to their employees they contribute the same amount of dollars to the HMO premium as they contribute to the traditional insurance plans (i.e., Blue Cross/Blue Shield and Prudential). Any difference in premium costs is collected through a payroll deduction.

HMO enrollment through private employers accounts for 59 percent of the total New Jersey HMO memberships. Many industries have been active in the HMO movement; in fact, all New Jersey HMO boards of directors have employer and/or union representation. Moreover, it is believed that positive support by industry is needed from the beginning, if an HMO is to be successful in a geographic area.

(b) **State Health Benefits Plan**—Government employees also have been a significant source of HMO enrollment. Through the State Health Benefits Plan (SHBP) seven HMOs offer membership to state government and participating county and municipal workers. Thirty-six percent of the New Jersey HMO membership is enrolled through the SHBP.

In spite of issues that often apparently strain the relationship between HMOs and the State Health Benefits Commission, HMO enrollment of eligible public employees has grown steadily. Membership drawn from the SHBP constitutes a significant proportion of total enrollment for most of New Jersey HMOs.

(c) **Medicaid**—In contrast, there is no Medicaid enrollment in New Jersey HMOs. There is, however, one

²The three organizational HMO models are:

(a) **Group Practice**—Physicians of several specialties and other health professionals contract with the HMO to deliver care from one or more centrally located health centers;

(b) **Staff Model**—Physicians and other providers work in a group practice setting but are salaried employees of the HMO rather than partners in a group practice; and

(c) **Individual Practice Association (IPA)**—Physicians and other health professionals work in their own settings, usually solo practice offices, where they provide care to both their prepaid patients and their fee-for-service patients.

HMO, Cumberland Regional Health Plan, which enrolls individuals who qualify as medically indigent under a Community Health Center contract. The lack of Medicaid enrollment reflects the inability of the State Department of Human Services and the HMOs to reach an agreement on an acceptable Medicaid contract. Points of controversy include (1) determination of the capitation rate, (2) determination of which services the HMOs are required to provide.

Thus, while HMOs are introducing competition to the segment of the health care industry that serves the working population, at this time they are not addressing the needs of the aged or the poor. In large part, this is due to the inability of government insurance systems that cover the poor and the elderly to offer adequate prepaid reimbursement for the provision of HMO services for these special populations. Contributing to the problem has been a less than aggressive pursuit of Medicaid and Medicare contracts by both the HMOs and the government bureaucracy.

HMO FINANCIAL ANALYSIS

As was stated previously, the HMO's ability to market its services successfully depends on several factors, more important of which is competitive premium structure. Related to the latter factor is the HMO enrollment levels within certain perimeters of time.

Financial breakeven occurs when HMO operating income equals HMO operating expenses. This breakeven point should be distinguished from cumulative breakeven which sums income and expenses over time. Many factors enter into the determination of financial breakeven dates. HMOs that are able to minimize fixed costs as a percentage of total costs usually attain breakeven at a lower number of enrollees. The plan can have facility or service expansion resulting in increased expenditure such that breakeven is not achieved. Other plans achieve breakeven from their inception due to their affiliation with commercial, third-party payers such as in the cases of Mercer Regional Medical Group, Southern Inter-County Medical Associates (Blue Cross/Blue Shield) and Southshore Health Plan (Prudential). Other plans may float in and out of financial breakeven month by month for reasons such as heavy utilization for certain months, but may or may not, in fact, achieve overall breakeven for the fiscal year.

To promote the expansion of HMO activity, the federal government has offered financial assistance to HMOs for development and expansion. Since the federal HMO Act was passed in 1973, the federal government has spent over \$300 million dollars to assist in HMO growth.

Grant funds are available to public and nonprofit private organizations, as follows:

1. **Feasibility grants**—An organization may be given a grant of up to \$75,000 to determine through surveys or other activities whether an HMO can be developed and can operate in the specific geographic area;
2. **Planning grants**—When feasibility is demonstrated, organizations may apply for a planning grant of up to \$200,000 per award. This phase of activity includes the development of the HMO marketing strategy and prepares the HMO for initial development; and
3. **Initial development grants**—Upon completion of planning, initial development grants are available to cover such activities as administrative and organizational arrangements, recruitment of personnel, the enrollment campaign, purchase of equipment, alteration and renovation of facilities, and development of quality assurance procedures.

The same type of grants are also available for HMO expansion activities. A lifetime maximum of \$2 million in support is available to an HMO for initial development, including any later expansion as a federally qualified HMO. Through June 30, 1980, the New Jersey HMOs were authorized to receive \$8,040,310 in federal grants.

In addition to the grant program, loans are available when a nonprofit HMO meets federal qualification standards. These loans help to cover operating deficits during the first five years of operation. These loans may not exceed \$2 million in any fiscal year nor more than a total of \$4.5 million over the five year period, and are to be repaid within 20 years. As of June 30, 1980, cumulative federal loan assistance to New Jersey HMOs totaled \$15,173,000.

The many components of an HMO must maintain a delicate balance if the HMO is to continue functioning. The relationships discussed previously, between marketing, premium and benefits, all equate to the provision of health services to residents of New Jersey. Critical to the successful provision of these health care services are the arrangements that the HMO has with its providers. The next section of this report discusses the types of contracts that exist between New Jersey HMOs and the providers of HMO health care services.

PROVIDER RELATIONS

The relationships with providers of care (physicians and hospitals) are analyzed carefully and continually by management, so as to contribute to maintaining the crucial income-expenditure balance of the HMO, as well as both patient and physician satisfaction. Both the hospital and physician provider types, in their own way, can have a significant impact on the cost-saving features of the HMO.

(a) **The Physician Provider**—As of December 31, 1980, there were more than 1700 physicians participating in New Jersey HMOs. The configuration of these physicians' services defines the type of HMO model. These models are as follows:

1. **Staff model**, in which participating physicians are professional employees of the HMO and are *salaried*. Examples are Health Care Plan of New Jersey, HIP of Greater New Jersey and Cumberland Regional Health Plan;

In staff model plans, as HMO membership increases, providers are added for frequently used specialty services. This sometimes leads to higher fixed costs in the staff model. As a result, less frequently used services may be provided through referrals to community physicians, based on a negotiated fee-for-service schedule;

2. **Medical Group model**, in which a physicians' group contracts with the HMO by accepting a fixed-dollar amount per enrollee (i.e., capitation) for services given. An example is Mercer Regional Medical Group, who is a provider group for Blue Cross/Blue Shield HMO. The physicians participating in the group may be paid by the group in various ways including hourly or, if full time, salaried. As with staff models, referrals are made outside of the group for less frequently used specialties;

3. **Fee-for service model**, in which the HMO contracts with community physicians through an Individual Practice Association (IPA). The physicians participating in the IPA, render medical services in their own office settings. They are compensated through the IPA on a negotiated fee-for-service basis. These fees may vary from one IPA to another, but they are basically a product of the physician's individual fee profile, and the fees charged by comparably trained physicians in the community of the HMO. A set percentage

(usually 15 to 20 percent) of the physician's fee is held back to place the physician at risk for overutilization of services. Crossroads Health Plan and CoMED are examples of fee-for-service compensated physicians, as well as SIMA and Southshore in Southern New Jersey.

(b) The Hospital Provider—Due to an experimental hospital reimbursement system based upon case-mix, arrangements for payment of inpatient hospital services in New Jersey are in a state of flux. However, some HMO plans are still able to negotiate arrangements with individual hospitals. These arrangements include the following:

1. Capitation agreements with a hospital. In this arrangement a hospital agrees to service the HMO's patients for a fixed amount per enrollee;
2. Blue Cross per diem rate. In this arrangement, the plan agrees to reimburse the hospital for patient stay at the rate that Blue Cross normally pays for a hospital day. This has been the most common arrangement in New Jersey;
3. Billed charges for fee-for-service. This arrangement is the least favorable to the HMO because they lack the ability to control or predict their hospital costs, when looking at payment to the hospital provider during budget projection periods.

Many of the HMOs also have agreements with hospitals to make intermittent payments with reconciliation at year end. In addition, some HMOs have risk arrangements with hospitals, whereby both parties (HMO and hospital) share in the benefits of hospital cost savings.

In 1978, amendments to N.J.S.A. 26:2H-1 et seq. (commonly known as S.446) gave the State Department of Health authority to set hospital rates for all payers (including HMOs) and to establish a Hospital Rate-Setting Commission. According to this legislation, rates are to be set equitably among all payers so as to address the full financial needs of hospitals, including indigency, bad debt and capital facilities. The methodology for the New Jersey Hospital Rate-Setting Program is based upon patient case-mix, with patients classified into a set of homogeneous classes called "Diagnosis Related Groups" (DRGs).

Under the DRG system, hospitals bill by the case, and payers are charged according to each patient's DRG classification. The inclusion of these additional financial factors dramatically increases hospital rates when each hospital enters the new system.

The DRG impact on HMOs derives from several forces, but one is the inability of HMOs to realize savings in hospital costs due to shorter lengths of stay. The hospital rate-setting legislation attempts to remedy this by providing payer differential to reflect the savings due to the shorter length of hospital stay of the HMO patient. Thus far, this differential has not been awarded due to quantification problems. Once the data are available, a retroactive length of stay adjustment is scheduled to be made.

HMO PREMIUMS

There exists a close relationship between HMO benefits and the premiums charged. Both are key factors in an HMO's ability successfully to market its services in the State.

HMO rates are based on the plan's administrative costs as well as health utilization of all members of the plan, except for variations based upon the number of persons in a family. This is known as the community rating system. Those HMOs that are not federally qualified (Blue Cross/Blue Shield HMOs and Cumberland Regional Health Plan) vary their group premiums according to the health care utilization

"In New Jersey, HMO subscribers used 463.38 hospital days per 1,000 members in 1979 . . . New Jersey Blue Cross . . . 612 hospital days per 1,000, a national HMO average of 412 per 1,000 and overall national average . . . of 800 days per 1,000."

experience of each group.

Since each HMO is a separate nonprofit corporation, their rates can and do vary. HMO rates may increase each year. All rates are reviewed by the New Jersey Department of Insurance, to insure that they are not excessive, inadequate or discriminatory.

Any comparative analysis of HMO versus Blue Cross/Blue Shield or commercial insurers' premium rates would be premature at this time. Resulting variations would be affected by factors which would make conclusions, at this time, speculative at best. For example, in 1977 the initial level of the HMO premium rates was comparatively low and experience on which to base their rates was absent. Subsequent experience resulted in a significant percentage of HMO rate increases. In addition, the growth and limited financial reserves, and the size of the HMOs as compared to Blue Cross/Blue Shield must be considered in making any comparisons.

UTILIZATION

Not unlike the importance of premiums and enrollment to the financial status of HMOs, utilization of costly resources, e.g., hospitals, is also a significant factor in maintaining the income/expenditure balance. This section of the report will present data on the utilization of services, and information on incentives and policies designed by the HMO industry to control utilization, thereby controlling costs.

HMOs have been credited with controlling health care costs by drastically cutting the number and length of hospital stays. In New Jersey, HMO subscribers used 463.38 hospital days per 1,000 members in 1979. This compares with a New Jersey Blue Cross rate of 612 hospital days per 1,000, a national HMO average of 412 per 1,000, and an overall national average for the general population of 800 days per 1,000. It should be noted, however, that the HMO membership may not correspond to the Blue Cross membership in terms of age, sex or health status, and that the national data includes a vast cross-section of the population.

The basic unit of service for reviewing ambulatory utilization is the encounter. An encounter is defined as face-to-face contact between a patient and a health care provider, resulting in service to the patient. In New Jersey the average number of ambulatory encounters per HMO member was 4.43 in 1979. This is compared to the national average for HMOs of 4.5 encounters, and a national average of the overall population of 5.3 encounters.

HMOs have programs specifically designed to control unnecessary utilization of expensive hospital services. This fact may impact on their lower hospital use compared to other insurers. More specifically HMOs have incentive programs and policies specifically designed to control hospitalization, while maintaining quality. These measures include

the following:

1. **Pre-certification of hospital admissions**—In the case of nonemergency admissions, the admitting physician must obtain authorization prior to hospitalizing a patient. Usually this involves notification of an inpatient care coordinator, who together with the medical director certifies both the admission and the length of stay. Recertification often is required to extend the stay beyond the number of days authorized;
2. **Concurrent stay review**—Hospital admissions, elective as well as emergency are certified as to medical necessity and appropriateness of the level of care, usually within 24 hours of admission;
3. **Retrospective analysis**—This includes Medical Care Evaluation Studies that are designed to determine whether the health care services provided were appropriate to the patient's needs, are of optimal quality and are organized and administered efficiently.

The utilization review and control programs thus mentioned, combine with other activities to provide a comprehensive utilization review/quality assurance program. Among these activities are (1) personnel selection and evaluation studies; (2) laboratory controls; (3) ambulatory utilization review and evaluation studies, including analysis of emergency room use; (4) physician productivity standards; (5) peer review; (6) member/provider education; (7) member satisfaction surveys, and (8) independent assessments by an outside organization. In the area of member satisfaction, CoMED conducts annual surveys of its membership to ascertain levels of satisfaction. In addition, Rutgers Community Health Plan is facilitating a comprehensive survey of its members to determine levels of satisfaction.

CONCLUSION

(a) **The Past**—During the past year, the HMOs in New Jersey have experienced various patterns of development. Some plans have had strong enrollment growth and have moved closer to their projected financial breakeven dates. For example, CoMED has experienced an average monthly increase in membership (i.e., new enrollees net of disenrollees) of 455 and projects a June 1982 breakeven date. Moreover, other plans which have experienced large membership increases, anticipate having to restrict enrollment of new groups due to limitations in their facility space. These plans are Rutgers Community Health Plan, Health Care Plan of New Jersey and the Blue Cross/Blue Shield HMO, Mercer Regional Medical Group. For other HMOs in New Jersey, namely, Southshore Health Plan and HIP of Greater New Jersey, it has been a year of slower growth.

Within the backdrop of what appears to be emerging as a cadre of successful HMOs, however, have occurred two total failures, in addition to one HMO operating almost to the point of failure. Central Essex Health Plan, the staff model HMO in Essex County ceased its operations in May 1979. In addition, Group Health Plan of New Jersey, the staff model HMO in Hudson County, ceased its operations and went into receivership in January 1980. Crossroads Health Plan, the IPA in Essex County, however, survived receivership in August 1980. It has been a year of complete reorganization for Crossroads, due to a past plagued with serious financial problems, most of which could be attributed to excessive hospital costs and poor management procedures. However, Crossroads has begun to rejuvenate itself.

(b) **The Present**—The problems of HMO failures as described above, have raised serious questions among sup-

“At this point in time, HMO enrollment in New Jersey represents about five percent of the total health care market in the State.”

porters and opponents of the HMO movement. Among these is the question of the HMO management's ability to perform tasks necessary to insure success; the ability to maintain a system that provides timely and accurate information on the HMO's operations at any point in time; and management's ability to monitor the financial viability of the HMO. Questions are also being raised as to the responsibility of the physician in an HMO to minimize hospital costs and to avoid practicing in a solo practice mode. In addition, questions are being raised concerning the large amounts of money that the federal government has given to unsuccessful and/or poorly managed HMOs. Finally, questions are being raised concerning the impact on enrollees as well as physicians when an HMO fails.

Measures are currently being considered to protect enrollees in cases of HMO bankruptcy. Such measures include more stringent capital reserve requirements for HMOs, more comprehensive insolvency insurance and hold-harmless regulation. (Hold-harmless regulation would protect HMO enrollees from efforts by providers to collect fees that are the responsibility of the HMO.) The need for hold-harmless regulation illustrates an impact of HMO failure on physicians as well as patients.

In the failure of Group Health Plan, physicians were left without compensation for services given to the HMO's members. Another possible impact of HMO failure is the possible interruption of the physician/patient relationship. Finally, the physician may incur a loss of any funds invested in the physician's corporation. Although not all of these issues have posed problems for New Jersey physicians, physicians in other parts of the country have been less fortunate when HMOs have failed.

(c) **The Future**—There have been indications of widespread interest in HMO development from local medical societies and community hospitals in New Jersey, but awareness of the problems that the existing HMOs have encountered probably has caused these groups to move cautiously toward any serious efforts at HMO development. However, expansion is expected of several of the operating HMOs.

Health Care Plan of New Jersey and Rutgers Community Health Plan are receiving federal funds for significant facility expansion. In addition, it is expected that HIP of Greater New Jersey will develop additional health centers in northern New Jersey if it succeeds in Hudson County. It is also expected that Blue Cross/Blue Shield's Medigroup Plan will look to new markets in the State if successful in Cumberland County.

In analyzing the State of New Jersey's "marketable" areas for HMO development, it is generally believed that northern New Jersey and the southern coastal areas are prime areas for HMO development. This is mainly because of the densely populated, highly industrial environment of the north, and the growing, developing areas of the coast, represented by

Monmouth and Ocean Counties. In fact, in Monmouth County, IPA groups already have been incorporated. In addition, in the Camden County area, there is an active movement to establish a hospital-based IPA.

Indications are that expansion of the HMO option to the rural areas in New Jersey will begin with satelliting by operational plans close to less remote areas. Included in this possibility is the merging of operational HMOs with Rural Health Initiative (a federally funded program) funding. The Urban Health Initiative and Rural Health Initiative Programs, with their subsidies for primary care, probably will provide opportunities for existing HMOs to expand into the inner cities as well as to rural New Jersey.

At this point in time, HMO enrollment in New Jersey represents about five percent of the total health care market in the State. This compares to the national HMO enrollment penetration of five percent also.⁵ These percentages have led to conclusions that the HMO movement in New Jersey and the nation is not a pressing force in providing health care services to Americans. In addition, the fiscally conservative mood of the country as well as the growing opposition to government regulation, has led to the conclusion that HMO growth and stability may be something of the past. However, before conclusions are drawn on these observations, other issues can be considered.

As discussed previously, although HMO failures in the State have caused some groups to move slowly toward embarking on HMO development generally, regulators, insurers and industry continue to see untapped, potentially sound markets for HMOs in the State. Moreover, employers continue to express concern over the rising cost of health care, and the HMO as a model for delivering health services, having proved that it can reduce hospital costs, probably will be looked at, at least initially, with an interested eye by unions and employers.

The lack of federal dollars to support new HMOs at this time appears to be a distinct reality. As a result, active federal financial support for HMOs over other modes of health care delivery appears to be a phenomenon of the past. However, as previously mentioned, private industry as well as private insurers now are taking active roles to support the HMO movement philosophically and to sponsor HMOs. This sponsorship has been in the form of HMO board memberships and the provision of large sums of money for HMO development, acquisition of established plans and management. Therefore, although the federal government's role in HMOs may diminish, much of the support will be carried on by private enterprise.

In the area of government regulation, the strong presence of government intervention in health care delivery, also may diminish within the next few years. However, government regulation likely will be substituted for something else. More specifically, an old concept that has resurfaced with the new administration is "competition." Proponents of this method of containing costs in the health care system view HMOs as *one* form of competition that will aid in controlling costs. Therefore, although regulation to support HMOs may be something of the past, there appear to be emerging possible substitutes of a similar nature. The Stockman/Gephardt bill is the earliest example.

SUMMARY

It appears the HMOs are not a phenomenon of the past, but are organizations with a future. Moreover, it appears that not only will they grow, but that additional competitive models will emerge, with heavy emphasis on prepayment and cost containment. Private industry will continue the prepayment movement with subtle support from the federal government.

Future Medical-Legal Problems

RICHARD E. BRENNAN, ESQ., and LEON G. SMITH, M.D., Newark*

Special laboratory tests requested to be done by a laboratory outside of the hospital—request denied—patient died of a curable disease. Who is responsible?

A patient¹ was seen in the hospital emergency room with chief complaint of dizziness and headaches of four-days' duration and was admitted under the care of an attending physician who requested a neurological consultation. A tentative diagnosis of viral encephalitis was made; special spinal fluid studies for fungal and viral tests in specialized laboratories outside the hospital were recommended. Despite the recommendation of the neurologist and the attending physician these diagnostic laboratory tests were overruled by the hospital pathologist, who regulated laboratory studies for out-of-hospital tests, on the grounds that they constituted an unnecessary expense inconsistent with hospital policy of cost containment under the "Diagnosis Related Groupings" Program (DRG).

The patient died of meningitis, without ever having had the benefit of viral or fungal studies. His widow has brought a civil wrongful death action for damages against the attending physician, the consulting neurologist and the hospital itself.

THE LIABILITY OF THE HOSPITAL

The "Diagnosis Related Grouping" represents a relatively new concept in health care reimbursement. Its emergence as a method of cost containment is essentially due to the Health Care Facilities Act N.J.S.A. 26:2H-1 *et seq.*, as amended 1978. The statute designates the Department of Health as the agency primarily responsible for development and administration of the state policy with respect to health planning, hospital and other health care services, and more specifically

cost-containment programs of all public and private health care facilities.

The Department of Health has attempted to institute the policies of N.J.S.A. 26:2H-1, including containment of the rising cost of health care services. The DRG program determines schedules for payment of hospital services by "medical abstracts" utilized in grouping patients by diagnostic classification. *It proposes 83 major diagnostic categories which then are subdivided into 383 distinct "medically meaningful" DRG groupings.* ("The DRG Maze," New Jersey Hospital Association, Princeton, New Jersey, 1979.) Since patients in each grouping are believed to consume similar hospital resources based upon diagnosis, age, length of stay, and surgical procedure, the cost of hospital care for an individual patient receiving inpatient services will be determined by the nature of his classification under the program. *The significance of the DRG reimbursement method in the present context is that it provides a motivation for hospitals to cut their costs by eliminating "unnecessary" treatment. If a hospital provides less services to a patient under a given diagnostic classification, thus reducing its own costs, it still will be entitled to the same reimbursement rate as if it had provided those services.*

Traditionally, hospitals have been under no obligation to

*Mr. Brennan is with the law firm of Shanley and Fisher; Dr. Smith is Director of Internal Medicine at St. Michael's Medical Center, Newark. Correspondence may be addressed to Dr. Smith at the Medical Center, 268 High Street, Newark, NJ 07102.

¹The facts are hypothetical and all medical and legal opinions contained in this article are based on such hypothetical facts.

"When a hospital . . . refuses care . . . against the advice of the treating physician, the hospital must be prepared to be held to the same standard of care to which private physicians would be held . . ."

accept or treat a patient absent a statutory duty. While patients still generally have no affirmative right to be treated in a hospital facility, more recent court decisions have imposed liability upon a defendant hospital where it has engaged in prior affirmative treatment, conferred a benefit upon another who has suffered because of reliance upon the care given, or where there exists as a matter of law a special relationship between the hospital and patient.

In the present case, a duty to provide a legally defined standard of care attached to the hospital at the time service was first rendered to the decedent. Once control over the person has been exercised, neither an individual nor the hospital can avoid liability for harm suffered as a result of unreasonable conduct.

It is the general rule that a hospital must give a patient that reasonable standard of care and attention which his particular condition requires. The standard is measured by the care customarily exercised by hospitals generally.

The principles of *respondeat superior* ordinarily will operate to render a hospital liable for wrongful acts of employees for their actions or omissions in the scope of their employment. Thus the important question in determining the possible liability of the hospital is whether its pathologist's conduct, in refusing to provide for the use of the special laboratory studies, was reasonable and acceptable under the circumstances.

The courts in New Jersey have made it clear that in utilizing their discretion, hospital officials must not contravene the public interest. *Davis v. Morristown Memorial Hospital*, 106 N.J. Super. 33 (Ch. Div. 1969). When they do, a hospital's policies may be held to be unsupportable and arbitrary. *Guerrero v. Burlington County Memorial Hospital*, 70 N.J. 344 (1976).

In *Greisman v. Newcomb Hospital*, 40 N.J. 389 (1963), the New Jersey Supreme Court held that hospital officials are properly vested with a large measure of managing discretion and to the extent that they utilize their fiduciary power reasonably toward the elevation of hospital standards and services, they will receive broad judicial support. But while reasonable and constructive exercise of judgment should be honored, courts will intervene where the hospital policies are unrelated to sound hospital standards and not in furtherance of the common good.

The hospital's position in the present case may arguably be that cost-containment measures under the DRG program are endorsed under the Health Care Facility Act as an equally important policy concern. However, the means by which the hospital has attempted to reduce its cost are not consistent with the ultimate goal of the program since it is designed to benefit the hospital financially without proper regard for the duty of the medical facility to care adequately for its patients. Upon entering a hospital, a patient reasonably expects that medical decisions regarding his care will rest with qualified

medical professionals, and not with hospital decision makers. To allow hospital officials to set absolute guidelines, which cannot match the physician's ability to consider the efficacy of treatment on an individual basis, will result in an unknown risk to a number of persons who may suffer illness and death due to the inadequacy of care. *Harv. J. Legis.* 15:603.58, April 1978. Although this philosophy of medical care undoubtedly makes physicians the "gate keepers" to medical facilities, there are alternatives, and costs can be controlled reasonably within private and public hospitals while they still serve the best interests of the public; i.e., second opinions, education of physicians regarding cost control measures, and licensing of costly medical equipment to a limited number of medical facilities in a given area.

When a hospital official or department head chooses to make a medical decision and refuses care which is otherwise available in that hospital, particularly when he does so against the advice of the treating physician, the hospital must be prepared to be held to the same standard of care to which private physicians would be held, since this is the standard which the patient reasonably would expect to be receiving.

LIABILITY OF THE CONSULTING PHYSICIAN

It appears that the consulting neurologist has provided care consistent with that which he is obligated to provide by law, and it is unlikely that he will be held liable for his involvement in the treatment of plaintiff's decedent.

Once a physician accepts a patient for consultation, he obviously owes a duty to render treatment in a manner consistent with the duty of licensed physicians imposed by law. The neurologist owed the decedent a duty to exercise that degree of skill normally exercised by other physicians who specialize in neurology. A physician cannot be held liable for malpractice so long as he does not depart from the above requirements of accepted medical practice to which he is obligated.

The inquiry with respect to the consulting physician is not merely one of defining the duty owed, but also when and where that duty ends. A consulting physician, unlike an attending physician, may be responsible for only a limited obligation and not for continued management of the patient's care. This is particularly true when there is a clear understanding among the patient, managing physician and consulting physician as to the limited nature of the consultation. Although it is accepted that if a physician is called for general care, he must give continued medical attention as the patient requires or possibly be held liable for *abandonment*; where a physician is called only for one occasion, he owes no other duty beyond conforming this initial visit with acceptable medical practice in the field.

The neurologist's tentative diagnosis was followed quickly by his recommendation that special laboratory tests be performed for purposes of ruling out other neurological diseases. Since it presumably can be shown that the special laboratory tests would have led to the proper diagnosis during this hospital admission, the overall advice of this neurologist was seemingly proper. With the support of expert testimony it could in fact be shown to be well within the accepted standard of care among neurologists. More importantly, his care could not be said to be a proximate cause of the decedent's death.

LIABILITY OF ATTENDING PHYSICIAN

The attending physician may be held liable for failure to pursue appropriate diagnostic testing and to inform the

"The conscientious physician should not be deterred from seeking necessary diagnostic treatment because the hospital refuses use of its facilities."

"The DRG program may be a salutary attempt to reduce the costs of the delivery of health care. However, strict compliance with the guidelines may subject a hospital and a doctor to civil liability in a medical malpractice action."

patient of the advisability of same.

A physician has a duty to exercise that degree of care, knowledge and skill ordinarily possessed and exercised in similar circumstances by other members of his profession. *Schuler v. Strelinger*, 43 N.J. 330 (1964). Failure to use such standard of care constitutes actionable negligence.

Although the fact that the attending physician consulted with a specialist in the field of neurology is evidence of due care, mere consultation with another physician does not in itself establish conclusively that due care was otherwise rendered, nor does reliance upon the consultant's opinion constitute a defense where the treatment was otherwise unskilled. Whether a consultation is adequate or whether it is properly considered by the attending physician or whether it is properly or improperly relied upon are determinations to be made by the jury.

An attending physician is required to use reasonable care in arranging for consultations with others and in his own testing and examination. The question in the case under discussion is whether, upon receiving advice from the hospital pathologist that special laboratory tests were being refused, he acted reasonably in not pursuing the possibility of obtaining this diagnostic procedure either at the defendant hospital or other medical institutions.

A physician's conduct in diagnosing a particular condition is judged by what he saw, knew, or ought to have known at the time the treatment was rendered. In light of the neurologist's recommendations and tentative diagnosis and the attending physician's own evaluation of the plaintiff's condition, it would appear that the attending physician had the duty to see that the tests were done.

The refusal by the hospital to permit the special laboratory tests to be utilized would not appear to terminate the attending physician's duty to inform himself, as well as the patient, as to the plaintiff's condition by use of diagnostic procedures normally utilized by physicians within the medical community.

Courts have held that when a physician does not avail himself of scientific means and facilities available for obtaining specific information from which a diagnosis can be made,

the result is not an error of judgment, which alone is not actionable, but negligence in failing to secure an adequate and factual basis to support that physician's diagnosis or judgment. It is not overly burdensome to expect that a treating physician will recommend to the patient that the procedure be performed elsewhere, as a necessary step in diagnosing the patient's ailment properly. The conscientious physician should not be deterred from seeking necessary diagnostic treatment because the hospital refuses use of its facilities. To hold otherwise is to permit the physician to reach a diagnosis without obtaining adequate scientific evaluation which the circumstances otherwise would warrant, leading to immeasurable damage to the patient who, relying on initial diagnosis, would not seek additional care. If failure to perform the laboratory tests under the circumstances can be shown by the plaintiff to be a departure from acceptable medical standards, mere refusal of the hospital to allow its facilities to be utilized for this purpose would not be an acceptable defense nor would it serve to excuse the defendant from otherwise using the proper methods in diagnosing the decedent's condition.

Because most patients have very little understanding of medicine, they must rely upon physicians to advise them of their medical status so they are able to make necessary decisions regarding their treatment. The requirement of reasonable disclosure by a physician to his patient is necessary to make such a decision possible. A physician is thus under the obligation to communicate specific information to the patient where due care demands it. When a physician fails to comply reasonably with this obligation to inform, his failure to do so may give rise to liability to the patient under the doctrine of "informed consent."

CONCLUSION

The DRG program may be a salutary attempt to reduce the costs of the delivery of health care. However, strict compliance with the guidelines may subject a hospital and a doctor to civil liability in a medical malpractice action. While cost is certainly a factor, the touchstone of malpractice liability remains "reasonable care under the circumstances."

Heart attack or stroke could make the best years of your life the worst.



You have loved ones, a future, good health. It could all be lost with a heart attack or stroke. And that happens. Last year, nearly one million Americans died of heart disease and stroke. And 200,000 of them died before retirement age.

The American Heart Association is fighting to reduce early death and disability from heart disease and stroke with research, professional and public education, and community service programs.

But more needs to be done.

You can help us support research and education by sending your dollars today to your local Heart Association, listed in your telephone directory.

**Put your money where
your Heart is.**



**American
Heart
Association**

WE'RE FIGHTING FOR YOUR LIFE

FAREWELL ADDRESS

A View of the Presidency*

AUGUSTUS L. BAKER, Jr., M.D., Dover

President 1980-1981

What is it like to be President of the Medical Society of New Jersey?" That question frequently has been asked this year. It might be characterized as frustrating but not futile.

I had expected a certain amount of frustration from seeing other doctors occupying this office before me. I realize that they had many things they wanted to do that should be done for the Medical Society. But, they were not able to get them done because there is no real power in the presidency of the Medical Society. If I, as your President, could say to you members of the Society that a certain action should be taken and the body of the Society would accept the decision, many great things could be accomplished. We are a group of individuals, but that does not mean our actions are futile and our Society cannot or will not respond to proper direction.

Since we are a group of individuals, we have to emphasize the importance of each individual's efforts in many areas. These areas include your medical, administrative, and political effectiveness. I hope that you will learn very soon to become as effective politically as you are medically because we do not practice medicine in an academic or scientific milieu, but in a progressively more confining and regulated political arena. In the eyes of many people we are seen as greedy obstructionists to the health care delivery problem, so we must be ready with our own positive plans to keep up the quality of care and assist in cost containment. Both of these items must be kept out of government hands if we are to be successful in providing proper medical service. After all, medicine is the only profession that spends its time trying to put itself out of business. Administratively we must join and support the activities of our hospital staffs and our county, state, specialty, and national societies.

There have been a number of specific items addressed this year:

MEDICAID EXPERIMENT

As many of you know, we have started a Medicaid experiment in Atlantic and Mercer Counties whereby the physicians can be reimbursed on a customary fee basis. It is expected that the participating doctors will become primary care physicians for these patients so that they no longer will be relegated to the hospital emergency rooms where the cost of treatment is three or four times as expensive as it is in a doctor's office. The planners hope that the new reimbursement system for office visits will encourage doctors to participate in this program to the fullest. I am anxious to

enlist your support. At the moment, it is only on a pilot basis in the two counties mentioned, but if it works there, I certainly will expect all of us to join enthusiastically in supporting the program.

PROFESSIONAL LIABILITY

The problem of professional liability will be with us always. We are hoping that further education of the physician in the area of risk management will reduce our losses. In many ways we are still our own worst enemy in this matter in that we fail in the simple process of personal relationships with our patients.

STATE BOARD OF MEDICAL EXAMINERS AND GOVERNMENT-SPONSORED PROGRAMS

We are attempting to cooperate with the State Board of Medical Examiners in the development of excessive fee regulations. They have been cool to our suggestions in this matter. The President-Elect has attended all of the meetings of the Board and the dialogue has been somewhat helpful to both parties. I feel that the problems that have persisted will be addressed considerably and will be resolved to the satisfaction of all concerned.

As this is being written, the fate of many government programs is in the balance and what the outcome will be is unclear. I feel that if the HSA's planning job is eliminated then some other agency will have to take over this task, and it probably will be done by a state ordered unit. The same is true of PSRO. If the PSRO is phased out, then the vacuum created in the peer review process now being done by the PSRO will have to be filled by some other organization. I am certain that both of these functions will not be lost, so we must see that the successors are suitable.

MSNJ HOUSE OF DELEGATES

Changes in the charter that have been approved by the Legislature will permit us to provide specialty, student, and other representation in our House. Both the reports of our management consultants and the Committee on Long Range Planning and Development recommend a smaller house of delegates. I think one of the problems that the House has had with this idea in the past was that the members feel that they are voting themselves out of office. However, attendance figures usually have indicated that a lot of elected delegates do not attend the meetings. If they were eliminated in the

*President's farewell address—presented before the House of Delegates, May 17, 1981, Meadowlands Hilton, Secaucus, N.J.

planning process for the meeting, many improvements in locations of the annual meetings could be made. Those of you who really are interested in the business of the society would still be here. So I would like to urge you to consider this carefully and, I hope, vote in favor of reducing the size of the House.

The size of the House can be based on dues-paying membership only. We have noticed that while the Society stays about the same size, the number of dues-payers has gone down in relation to the number of those who are dues-exempt. If only the dues-paying members were taken into consideration in making allocation of the number of delegates per county, a smaller house would result. I would like to point out that the Pennsylvania Medical Society, with about twice as many members, has a House of Delegates half the size of ours.

In closing, I would like to express my thanks again to the Officers and Trustees of the Society who worked very

diligently this year, and to those of you who have been attending the Trustees' meetings on Sunday in Lawrenceville. The members of the various councils and committees who have been giving their time generously are to be thanked and commended for this activity.

I am sure that you all realize that the Medical Society would not function without our very fine staff in Lawrenceville. This not only includes the four senior officers, Mr. Maressa, Mr. Lucci, Mr. Johnson, and Mr. White, but also the secretarial staff which supports their actions. Of course, I am more particularly aware of Mr. Maressa's staff, consisting of Diana Gore, Marie Fisher, and Kathy Boccardo, who have provided me with tremendous support this year, and I want to thank them again.

When I took this office they told me to smile and be happy because things could be worse. So I smiled and I was happy, and I hope things did not get worse.

A Case of "Lyme Disease" Acquired in New Jersey*

LAWRENCE L. WARD, M.D., Fort Defiance, Arizona

A single case of erythema chronicum migrans is presented. Historical data suggest that this case was acquired in New Jersey. The diagnosis of "Lyme Disease" should be considered for expanding annular rashes, one component of the syndrome in patients in the New Jersey geographical region, as well as Connecticut, Rhode Island, New York and other areas of outbreak.

The syndrome of erythema chronicum migrans and Lyme arthritis has been described in the literature.¹ It appears to be an arthropod-borne disorder characterized by fever, skin rash (erythema chronicum migrans), oligoarticular arthritis, radiculitis, and migratory arthralgias. Since its original description in Lyme, Connecticut, there has been no specific laboratory criterion for diagnosis. When the rash occurs, its appearance and expanding, annular nature can be diagnostic.

Presented herein is a case with the typical onset of rash and radiculitis within three weeks of the suspected insect bite.

CASE REPORT

A thirty-six-year old male, seen in June 1978, complained of an enlarging right flank rash and shooting pains in the same region. Four weeks previously he had taken a three-day hike on the Batona Trail in New Jersey, from Wharton State Forest to Lebanon State Forest. He recalled receiving many insect bites, (but no specific tick bites) on his back and elsewhere. After one week he developed a red rash in the right flank area; four days later a persistent pressure-type sensation developed in the right first lumbar (L1) dermatomal distribution.

The rash continued to enlarge despite a trial of hydroxyzine for pruritis and warm compresses. The pain increased in intensity, being worse in the evenings, with occasional episodes of severe shooting radicular pain occurring. Aspirin gave no relief.

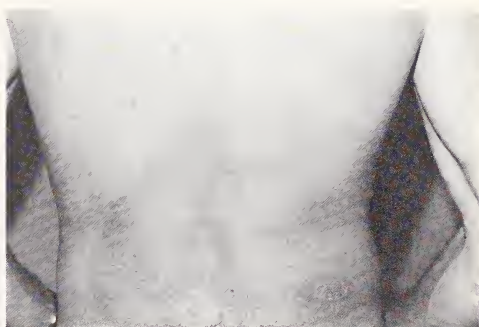


Figure 1. The characteristic rash of erythema chronicum migrans. Note the increased band-like erythema of the periphery, and the central maculopapule.

The patient's general health was excellent. He jogged three miles daily, did not smoke or drink, took only aspirin and hydroxyzine as noted, and had no history of surgery or major

*From the Department of Family Medicine, Chestnut Hill Hospital, Philadelphia. Correspondence may be addressed to Dr. Ward at P.O. Box #59, Fort Defiance, Arizona 86504.

¹Steere AC, Malawista SE, Hardin JA, Ruddy S, Askenase PW, Andiman WA: Erythema chronicum migrans and Lyme arthritis: The enlarging clinical spectrum. *Ann Intern Med* 86:685-698, 1977.

illness. There was no family history of arthritis.

Examination in June revealed a well-developed, well-nourished male in moderate discomfort with complaints of a right flank pain. Vital signs were normal. The sole abnormality was a 30 cm diameter erythematous macule in the right flank and back area (figure 1). The periphery of the rash showed a 2 cm band of increased erythema; centrally there was a 5 by 9 cm exfoliative maculopapular area. The entire rash blanched with pressure. There was no dermatomal sensory abnormality; no regional adenopathy was found.

The diagnosis of erythema chronicum migrans with radiculitis was made clinically; no laboratory studies were obtained. An empirical trial of penicillin V potassium 250 mg q.i.d. for one week and indomethacin 25 mg q6h for radicular pain was begun. Telephone followup revealed that the intense evening pain diminished after three days, and all pain was gone after one week. The rash had completely cleared after two weeks. Telephone contact six months later revealed

the patient to be entirely symptom free since the acute event.

SUMMARY

This case suggests that erythema chronicum migrans, one component of the "Lyme Disease" syndrome, can be contracted in New Jersey, and should be a diagnostic consideration for expanding annular rashes in this geographical region. This patient's response after penicillin and indomethacin is not inconsistent with the known natural history of the disease, and no therapeutic conclusions can be drawn. The syndrome is characterized by recurrences of inflammatory arthritis in many patients, and its recognition can help avoid much diagnostic expense and patient anxiety.

Acknowledgements—The author wishes to thank Nancy J. Gettes, M.D., and William N. Mebane, M.D., for their assistance in the acquisition of the photograph for and preparation of this paper.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physicians Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

This information is compiled by the Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Arnold and Marie Schwartz College of Pharmacy and Health Sciences, Long Island University.*

1. Do you have information concerning effectiveness of low-dose aspirin for inhibiting platelet aggregation?

Aspirin, at a recommended dose of 1300 mg per day, is now indicated for reducing risk of recurrent transient ischemic attacks (TIAs) or stroke in men (not women) who have had transient ischemia of the brain due to fibrin platelet emboli. The drug inhibits platelet aggregation and interaction with collagen by blocking an enzyme that mediates prostaglandin formation. Unfortunately aspirin in large doses is associated with significant incidence of adverse effects and also decreases prostacyclin, a substance that causes vasodilation and potentially inhibits platelet aggregation. Lower doses of aspirin may be as effective in inhibiting platelet aggregation, have less inhibiting effect on prostacyclin and decrease incidence of adverse reactions associated with the presently recommended dosage regimen.¹⁻³

Paccioretti and Block¹ studied the effect of single doses of aspirin, 81 to 325 mg, on platelet aggregation in seven subjects. Eighty-one mg of the drug inhibited platelet aggregation as quickly, and to as great an extent, as 325 mg of aspirin. Platelet aggregation inhibition usually occurred within 30 minutes and lasted for the life of platelets affected.

Stuart⁴ studied effects of 300 and 3600 mg of aspirin administered for varying lengths of time on platelet function. Significant inhibition of collagen-induced platelet aggregation was achieved with 300 mg of aspirin per day and effect was not enhanced in either rate or degree by larger daily doses. The onset of effect occurred as early as 15 minutes after the first dose of aspirin and was maintained by the 300 mg daily dose.

Masotti *et al.*⁵ explored the effect of 320 to 960 mg per day of aspirin on inhibition of prostacyclin production and platelet aggregation in 25 healthy volunteers. Inhibition of platelet aggregation was proportional to doses of aspirin in the range 2 to 5 mg/kg. Higher doses significantly inhibited prostacyclin production but only slightly increased inhibition of platelet aggregation.

In conclusion, the recommended dose of aspirin is 1300 mg/day to reduce risk of recurrent TIAs in men due to fibrin platelet emboli. Lower daily doses of aspirin appear effective in inhibiting platelet aggregation, inhibit prostacyclin less, and may reduce adverse reactions. Further clinical trials utilizing lower doses of aspirin appear warranted to determine effectiveness in reducing risk of recurrent TIAs in men.

REFERENCES

1. Paccioretti MJ, Block LH: Effects of aspirin on platelet aggregation as a function of dosage and time. *Clin Pharmacol Ther* 27:803-809 (June) 1980.
2. Anon: FDA Drug Bulletin, Department of Health, Education and Welfare, Rockville, Md. 102-6 (Feb) 1980.

3. Anon: Aspirin after myocardial infarction. *Lancet* 1:1172-1173 (May 31) 1980.

4. Stuart RK: Platelet function studies in human beings receiving 300 mg of aspirin per day. *J Lab Clin Med* 75:463-471 (Mar) 1970.

5. Masotti G, *et al*: Differential inhibition of prostacyclin production and platelet aggregation by aspirin. *Lancet* 2:1213-1216 (Dec 8) 1979.

2. Would you please supply information concerning the use of lithium carbonate in the treatment of granulocytopenia?

Reversible leukocytosis is a documented side effect of lithium therapy.¹ Investigators successfully have used this side effect to treat leukopenias due to various pathologic and iatrogenic causes.^{2,3,5}

Gupta *et al.*² utilized lithium carbonate to treat ten patients with granulocytopenia associated with Felty's syndrome (classic rheumatoid arthritis, persistent granulocytopenia, and splenomegaly). The drug was administered for six weeks in oral doses of 600 or 900 mg per day. Patients who received the higher doses exhibited a significant increase in granulocytes with minimal side effects. More importantly, none of these patients developed infections due to granulocytopenia during the study period.

Yassa *et al.*³ utilized 900 mg per day of lithium to treat phenothiazine or barbiturate-induced leukopenia in three patients with chronic schizophrenia. Over a three-week treatment period a significant increase in neutrophils, as well as in total white blood count, was observed. After discontinuation of the lithium, there was a steady decline back to base levels.

Stein *et al.*⁴ provided data from six healthy volunteers that indicated 900 mg per day of lithium caused true granulocytosis rather than just mobilization of granulocytes from bone marrow reserves and/or marginated pools. Results showed a mean increase in circulating granulocytes of 29 percent, an increase in marrow reserves of 36 percent, and insignificant decrease in marginated granulocytes. Granulocyte function was not effected detrimentally by lithium.

A study by Lyman *et al.*⁵ is typical of recent reports indicating effectiveness of lithium carbonate to control

*The Center serves as a source of intelligence on therapeutic and pharmaceutic information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm. D.; Pongsri Sangkachand, M.S., R.Ph.; D.M. Biondi, R.Ph.

leukopenias after chemotherapy. Forty-five of 70 patients who received chemotherapy and radiation therapy for bronchogenic carcinoma received lithium carbonate. The non-lithium group (control) experienced significantly more severe febrile episodes, more days in the hospital with fever, and more infection-related deaths. Other measured parameters seemed to show use of lithium in conjunction with chemotherapy was beneficial in lowering risk of infection and improving the course and scheduling of treatment for the chemotherapy patient.

In conclusion, lithium carbonate appears to cause a granulocytosis that may be utilized clinically.

REFERENCES

1. Goodman S, Gilman A, eds: *The Pharmacological Basis of Therapeutics*, 5th Edition. New York, Macmillan, 1975, p. 793.
2. Gupta RC, Robinson WA, Smythe CJ: Efficacy of lithium in rheumatoid arthritis with granulocytopenia (Felt's syndrome). *Arth Rheum* 18:179-184 1975.
3. Yassa R, Nair V, Schwartz G: Treatment of leukopenia with lithium carbonate: A preliminary report. *Am J Psychiat* 135:1423-1424 (Nov) 1978.
4. Stein RS, et al: Lithium-induced granulocytosis. *Ann Intern Med* 88:809-810 (June) 1978.
5. Lyman GH, Williams CC, Preston D: The use of lithium carbonate to reduce infection and leukopenia during systemic chemotherapy. *N Engl J Med* 302:257-260 (Jan) 1980.

3. Do anticholinergic drugs used in parkinsonism have a potential for abuse?

Trihexyphenidyl (sold as Artane®) and benztropine (sold as Congentin®) are synthetic anticholinergic agents used as adjuncts in the treatment of parkinsonism and extrapyramidal symptoms secondary to neuroleptic therapy.¹ These drugs have been shown to have an abuse potential.²⁻⁶

In Britain where trihexyphenidyl was available without a prescription prior to 1964, it was used by young people for its hallucinogenic properties.

Rubinstein² reported a case that involved a 27-year-old woman who exhibited bizarre behavior and admitted abusing trihexyphenidyl. She feigned muscle stiffness to obtain prescriptions for this drug from several physicians. The woman said that 15 mg once or twice daily induced an animated and pleasant hallucinogenic state. Moreover she reported that her methods for obtaining antiparkinsonism drugs were widely used by drug abusers known to her.

MacVicar³ reported a case that involved a 30-year-old man prescribed trihexyphenidyl to treat dystonic reactions associated with use of haloperidol (sold as Haldol®). The patient admitted that self-medication with 15 mg of trihexyphenidyl brought about a toxic psychosis with visual hallucinations and a strong need to externalize. Apparently benefits outweighed anticholinergic side effects and the patient continued the abuse.

Bolin⁴ described a 32-year-old woman prescribed trihexyphenidyl for a spastic disorder. Treatment improved symptoms and induced mild euphoria. As her life became increasingly stressful, she began self-medicating with the drug, eventually reaching a dose of 24 to 30 mg daily. Ultimately the subject developed a toxic psychosis, paranoid symptoms and atropinism.

Goggin et al.⁵ discussed a case that involved a 40-year-old chemist who received trihexyphenidyl to treat akathisia secondary to use of thiothixene (sold as Navane®). The man felt that the trihexyphenidyl had a definite antidepressant effect that the other drug lacked. After his physician discontinued trihexyphenidyl, he synthesized and ingested the impure chemical to obtain the feeling of well being that the drug had given him.

Although these citations report the possible abuse potential of trihexyphenidyl, there are several cases of toxic psychosis associated with benztropine one of which was a deliberate overdose by a schizophrenic patient.⁶

One should be aware of the abuse potential of trihexyphenidyl and benztropine. Caution is advised in prescribing these drugs especially in those with a tendency for drug abuse.

REFERENCES

1. Buck R: Drugs and the treatment of psychiatric disorders, in Goodman LS, Gilman A (eds): *The Pharmacological Basis of Therapeutics*. New York, Macmillan 1975, pp. 227-244.
2. Rubinstein JS: Abuse of antiparkinsonism drugs—Feigning of extrapyramidal symptoms to obtain trihexyphenidyl. *JAMA* 239:2365-2366 (June) 1978.
3. MacVicar K: Abuse of antiparkinsonian drugs by psychiatric patients. *Am J Psychiat* 134:809-811 (July) 1977.
4. Bolin RR: Psychiatric manifestations of Artane® toxicity. *J Nerv Ment Dis* 131:256-259, 1960.
5. Goggin DA, Solomon GF: Trihexyphenidyl abuse for euphoric effect. *Am J Psychiat* 134:459-460 (Apr) 1979.
6. Woody GE, O'Brien CP: Anticholinergic toxic psychosis in drug abusers treated with benztropine. *Comprehensive Psychiatry* 15:439-441 (Sep/Oct) 1974.

Supplementary Foods for Infants*

CALVIN W. WOODRUFF, M.D., Columbia, Mo.

During the last century, practices of infant feeding in the United States and much of the Western World have changed from a dominant pattern of breast-feeding for one or more years, through the use of formulas consisting of dilutions of fresh or evaporated milk and, most recently, a renewed interest in and a growing scientific rationale for breast-feeding. During this time, practices concerning the supplementation of human milk or its substitutes with other foods and specific essential nutrients have varied from starting such feeding at the age of one year to competition among mothers to begin "solid" foods as early as possible. The purpose of this article is to review the information on which recommendations for supplementary feedings are based.

Human milk or prepared formula in amounts producing normal growth patterns meet all of the nutritional requirements of full-term infants for the first six months of life.¹ Breast-fed infants of healthy mothers have similar weight gains throughout the world until about six months of age when growth may slow if supplementary food is not available to the infant. The exact age at which current prepared formulas need supplementation has not been established but can be assumed to be similar. Before the age of six months, the only supplements which need to be considered are iron, vitamin D, and fluoride.

IRON

Milk from either dairy animals or nursing mothers contains little iron. However, the small amount (0.3 to 0.4 mg/L) in human milk is well absorbed by the nursing infant with an average figure being 50 percent. The specific biochemical factors which are responsible for its high bioavailability are not yet known. Cow's milk-based formula (iron content about 0.8 mg/L) has a bioavailability of about 10 percent so that the net absorption is nearly half of that in human milk. The iron in fortified formulas (12 mg/L) is less efficiently absorbed (about 4 percent) but the amount retained is larger. Studies² of breast-fed infants show negligible iron deficiency anemia under six months of age; infants fed diluted cow's milk formulas without added iron may develop anemia by the age of four months; and infants fed iron-supplemented formulas rarely become anemic. There is evidence that feeding supplementary foods to nursing infants between four and six months interferes with their iron absorption.

Because some of this information is relatively recent, it has not yet been incorporated into the recommendations of official bodies or individual reviewers. Although the administration of iron to infants is a well-known public health measure,³ the way in which this type of prevention is applied to individuals should be related to their particular needs. There is general agreement that prepared formulas based upon either cow's milk or soy protein should contain added iron and that iron deficiency is unlikely when this practice is

followed. However, the breast-fed infant, especially the exclusively breast-fed infant, does not need an iron supplement before feeding of supplementary food is begun at about six months of age. At this time iron-fortified cereal appears to be an adequate source of iron.

VITAMIN D

Rickets has reappeared in the U.S. population and the question of vitamin D usage needs review. Excluding rickets caused by metabolic disease and an abnormally high requirement of vitamin D, most of the rickets recently reported has been in breast-fed infants.

Much evidence suggests that deprivation of sunlight, rather than failure to administer vitamin D supplements, is the basic cause. Nursing mothers who wear dark clothing for cultural or religious reasons apparently secrete milk which contains reduced amounts of vitamin D.⁴ Air pollution and cloud cover during the winter months also can reduce the activation of 7-dehydrocholesterol in the skin by ultraviolet light. Pigmented skin is also a factor and many of the recently reported cases have been in blacks where a combination of the above factors exists.⁴ When sunlight is available to mother and infant, supplementation with vitamin D is unnecessary. Probably for most of the U.S., 300 to 400 I.U. of vitamin D is supplied by prepared formulas and similar amounts should be given to nursing infants when deprivation from sunlight is suspected.

FLUORIDE

Present recommendations for fluoride supplementation are based upon the amount of fluoride in the water supply and are difficult to extrapolate into the first year of life.⁵ Human milk contains little fluoride whether the mother's intake is high or low. Formulas are manufactured with low fluoride water to avoid overdosage when diluted with water of varying fluoride content. Epidemiological studies on the role of fluoride intake in preventing dental caries have not yet been extended into the first year of life. There is some doubt concerning the effect of fluoride before eruption of the teeth. Because of this lack of specific information concerning fluoride in the first year of life, recommendations take different approaches. One is to recommend the routine use of fluoride from birth onwards. Another is to depend on the amount of fluoride in the water supply with supplements used only when the water supply contains less than 0.7 ppm. The intake of water is quite variable during the first year of life. One recent recommendation has compromised on the phrase "soon after birth" which reflects our lack of specific information concerning this question.⁶

*Reprinted with permission of *Contemporary Nutrition* 6:1 (Jan) 1981, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Woodruff is Professor, Department of Child Health, University of Missouri, Columbia, Missouri 65212.

When breast-feeding is recommended as the sole source of nutrition for infants, the prescription of supplements of iron, vitamin D and fluoride would not seem necessary except in unusual circumstances.

SUPPLEMENTARY FEEDING

In anticipation of nutritional need and depending on developmental readiness, the infant between four and six months of age can benefit from beginning to acquire lifelong eating habits.⁷ There are two major objectives: to appreciate and enjoy a variety of foods and to learn to keep caloric intake and output in balance. At this age the infant learns to eat from a spoon and to express both eagerness for food and satiety. Although precooked infant cereal fortified with iron is the food usually started first, the order in which strained fruits and vegetables are added is unimportant. Variety in the diet can be thought of in two ways: the basic four food groups or variety in such aspects of food as taste, color, consistency and temperature. Infants consuming diets monotonous in one or more of these attributes are at risk of developing nutritional deficiency. During the period of introduction of supplementary foods, it is more important for the infant to learn to enjoy foods of differing tastes and colors than to have an arbitrary amount of each food since breast milk or formula still supplies the major portion of the calories and essential nutrients. At first the consistency will be that of strained foods. As development of motor skills, such as swallowing small particles and a pincer grasp occurs, the infant begins to feed himself and to begin the transition from specially prepared foods to a modified adult diet. Temperature variation, so important to adults, begins. By the age of one year, most infants have completed this transition.

OTHER MILK FEEDINGS

In 1976, the Committee on Nutrition of the American Academy of Pediatrics published standards for infant formula.⁸ These standards have been recognized as the best possible estimate of the nutritional requirements of infants during the first year of life. The question often arises concerning the nutritional adequacy of other milk feedings as substitutes for infant formula.

Cow's milk in undiluted form contains amounts of protein and electrolytes which exceed the maximum limits of these standards. When diluted with water and with added carbohydrate, which was a practice widespread a generation ago, cow's milk in either fresh or evaporated form is lacking in ascorbic acid, tocopherol (vitamin E), and essential fatty acids. It also needs to be supplemented with iron. There is increasing evidence that pasteurized, homogenized, fresh cow's milk, particularly when consumed in large amounts, is associated with occult blood loss.⁹ Even ordinary amounts (less than one quart daily) have been associated with biochemical iron deficiency when compared with a formula not fortified with iron.¹⁰ Although the mechanism by which fresh cow's milk produces occult blood loss is not yet known in detail, it is most likely due to immunologic immaturity of the infant intestine. Thus, it seems wise to recommend that fresh cow's milk not be used in infant feeding until the intestinal tract reaches immunologic maturity, which probably occurs toward the end of the first year of life.

Skim milk, although cheap, has all the drawbacks of undiluted cow's milk. It does not meet the minimum requirement for fat, even when infant foods make up a significant proportion of the total calories.¹¹ A study has shown that

infants did not gain weight at the expected rate on *ad libitum* skim milk feedings. Fat calories are needed by infants in addition to their requirements for fat-soluble vitamins and essential fatty acids.

OBESITY

Since the first year of life is a time of rapid development of behavioral patterns including those involved in food intake, achieving a balance between energy intake and energy needs can be part of this developmental process. Monitoring the growth in height and weight is part of health care. The use of growth charts, such as those published by the National Center for Health Statistics, is necessary to relate the growth pattern of the individual infant to the population in which he lives. Although there is considerable variation in size, the rate of growth generally follows the same pattern. An infant who gains at a rate which soon places him above the 95th percentile for weight needs a review of his caloric intake and the circumstances surrounding his feeding. Is food used as a pacifier or as a reward? What does his caretaker(s) know about his individual caloric needs? Although the average caloric requirement for the first year of life is stated to be 100 to 110 kcal/kg/day, the standard deviation is not well defined. Some infants thrive and grow on intakes less than average, and others eat more without gaining excessive weight. Only individual understanding and management based upon the specific circumstances are effective and may be difficult. Although the evidence linking infantile obesity to obesity in childhood and adulthood is still not conclusive, rapid weight gain in infants should not be ignored.

SUMMARY

Either breast-feeding or the use of an iron-containing infant formula meets all of the nutritional needs of the infant for the first six months of life when available in amounts which result in normal growth. The goal of supplementary feeding is the development of lifelong eating patterns which will maintain optimal health. The introduction of supplementary foods is based upon both nutritional need and developmental readiness.

REFERENCES

1. Woodruff CW: The science of nutrition and the art of infant feeding. *JAMA* 240:657-661, 1978.
2. Dallman PR, Siimes MA: *Iron Deficiency in Infancy and Childhood*. International Nutritional Anemia Consultative Group, Nutrition Foundation, New York, 1979.
3. Foman SJ, Filer LJ, Jr., Anderson TA, et al: Recommendations for feeding normal infants. *Pediatr* 63:52, 1979.
4. Bachrach S, Fisher J, Parks JS: An outbreak of vitamin D deficiency rickets in a susceptible population. *Pediatr* 64:871-877, 1979.
5. Committee on Nutrition, AAP: Fluoride supplementation: Revised dosage schedule. *Pediatr* 63:150-152, 1979.
6. American Public Health Association Position Paper: Infant feeding in the United States. *J Am Pub Health Assoc* Feb. 1981 (in press).
7. Committee on Nutrition, AAP: On the feeding of supplementary foods to infants. *Pediatr* 65:1178-1181, 1980.
8. Committee on Nutrition, AAP: Commentary on breast feeding and infant formulas, including proposed standards for formulas. *Pediatr* 57:278-285, 1976.
9. Wilson JF, Lahey ME, Heiner DC: Studies on iron metabolism: V. Further observations on cow's milk-induced gastrointestinal bleeding in infants with iron-deficiency anemia. *J Pediatr* 84:335-344, 1974.
10. Woodruff CW: Iron deficiency in infancy and childhood. *Pediatr Clin N A* 24:85-94, 1977.
11. Foman SJ, Filer LJ, Ziegler EE et al: Skim milk in infant feeding. *Acta Paediatr Scand* 66:17-30, 1977.

Golden Merit Awards

At ceremonies held on May 16, during the 215th Annual Meeting of the Medical Society of New Jersey, Meadowlands Hilton, Secaucus, the following received MSNJ's Golden Merit Award indicating fifty years of medical practice.

Atlantic County

Harold Jerome Bayer, M.D. Louisville '31
Leo Kahn, M.D. Jefferson '31
Russell Rosario Rubba, M.D. Hahnemann '31

Bergen County

Vance Thompson Alexander, M.D. Vanderbilt '31
Basil James Ellmers, M.D. Tufts '31
Isidore Frimmer, M.D. New York Medical '31
Nancy Nun Hsieh, M.D. Shanghai '31
Frederick Richard Kanning, M.D. Minnesota '31
Samuel Legato, M.D. Bellevue '31
Heniz Israel Lippman, M.D. Berlin '31
Frank Alfonso Patti, M.D. Long Island '31
James Moore Ruegsegger, M.D. Western Reserve '31

Burlington County

Freeman Weeks Metzger, M.D. Pennsylvania '31

Cape May County

Carl Nash Ware, M.D. Hahnemann '31

Cumberland County

Kenneth Ellsworth Corson, M.D. Temple '31
Maurice Nicholas Harris, M.D. Georgetown '31

Essex County

Christopher Abbott Beling, M.D. Columbia '31
Marcus Theodore Block, M.D. Rush '31
Joseph A. Bocchini, M.D. Long Island '31
Thomas Cahill Davis, M.D. Columbia '31
Oscar Ralph Deutel, M.D. Jefferson '31
Felix Joseph Di Fino, M.D. George Washington '31
William H. Fost, M.D. Edinburgh '31
Arthur Attilio Giffoniello, M.D. Georgetown '31
Gerald Weldon Hayes, M.D. Northwestern '31
Charles Edmund Kiessling, M.D. Cornell '31
William Alexander Loeb, M.D. University of New York '31
*George Anthony Maggio, M.D. George Washington '31
John F. Masterson, M.D. Maryland '31
Thomas Gibney McAveney, M.D. Long Island '31
Sigismund John Ostrowski, M.D. Georgetown '31
John Richard Pavia, M.D. Vermont '31
Irving H. Plain, M.D. Long Island '31
Clifford Winfield Quad, M.D. Vermont '31
Emanuel Rosen, M.D. Syracuse '31
Raymond Lawrence Russomanno, M.D. Loyola '31
F. Harry C. Schurman, M.D. Vermont '31
Walter Stanecky, M.D. Poland '31
Clarence Campbell Stiles, M.D. New York University '31
Herman Harold Tillis, M.D. Louisville '31
J. Harmon Wilson, M.D. Hahnemann '31
Coler Zimmerman, M.D. Jefferson '31

Hudson County

G. Thomas DeFusco, M.D. Georgetown '31

Harry Feinberg, M.D. Michigan '31
Max Finkelstein, M.D. Columbia '31
John J. McCarthy, M.D. Georgetown '31
John Willis McLoughlin, M.D. Columbia '31
Leon Reznikoff, M.D. Berne '31
John J. Scott, M.D. Bellevue '31

Mercer County

William Cohen, M.D. Pennsylvania '31
John T. Dimun, M.D. Pennsylvania '31
Henry L. Drezner, M.D. New York Medical '31
Thomas Kessinger Rathmell, M.D. Jefferson '31

Middlesex County

Howard E. Adler, M.D. Prague '31
Henry A. Belafsky, M.D. Long Island '31
Benjamin F. Glasser, M.D. New York Medical '31
Solomon Goldman, M.D. Creighton '31
Murray Benson Jacobson, M.D. George Washington '31
James J. O'Connell, M.D. Georgetown '31
Joseph F. Sandella, M.D. Bellevue '31
*William Stein, M.D. Syracuse '31

Monmouth County

Francis Wade Holman, M.D. South Carolina '31
Edward Kuchlewski, M.D. Ohio '31
David Wade McCreight, M.D. Ohio '31
Albert Schmidt, M.D. Hahnemann '31

Morris County

Anton Jurkans, M.D. Latvia '31
William G. Talmage, M.D. Medical College of Virginia '31

Ocean County

Raymond Abbott Taylor, M.D. Jefferson '31

Passaic County

Edward Coleman Edlkraut, M.D. Georgetown '31
James Severin Gallo, M.D. Columbia '31
Samuel Gordon, M.D. St. Louis '31
Max Magnes, M.D. Washington '31
William Alexander Marrocco, M.D. Georgetown '31
Robert Antheleme Prince, M.D. Pennsylvania '31
Wolfgang F. Vogel, M.D. Leipzig '31

Salem County

Harry Franklin Suter, M.D. Jefferson '31
John Zappala, M.D. Hahnemann '31

Union County

Harry Randolph Boffman, Sr., M.D. Meharry '31
Max Ehrlich, M.D. Michigan '31
*Winthrop Huntington Hall, M.D. Virginia '31
*Edward Thomas Lynch, M.D. Jefferson '31
Norman Lovell Murray, M.D. Toronto '31
Meyer Theodore Weissman, M.D. Tufts '31

*Awarded posthumously

This publication is available in microform.



University Microfilms International

Please send additional information for _____
(name of publication)

Name _____

Institution _____

Street _____

City _____

State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

Role of Humanities in a Medical Education: Attitudinal survey of members of the Faculty Council of the New Jersey Medical School*

Jonathan D. Klein

An interview was developed to sample opinions of members of the Faculty Council regarding the humanities and their role in a medical education. Thirteen of the fifteen respondents involved in patient care believed there was an important role. Eight of eleven not involved in patient care felt the proper time to be during premedical education. Most faculty members were unaware of existing efforts, but favored an integrative approach to human values and patient care teaching.

A formal interview was developed to display a sampling of faculty opinion regarding the role of the humanities, especially the areas considered medical humanities (ethics, human values) within a medical education. The Faculty Council was chosen as a group because it is composed of department chairpersons and elected at-large members of the faculty. While this is not necessarily representative of all faculty opinion, it is a group especially significant to the goals of the CMDNJ College-Wide Health Care Humanities Program as the Council is the academic governing body of the school which determines the fate of curriculum recommendations emanating from the Academic Policies and Programs (AP)² Committee of NJMS.

*This study, part of CMDNJ's Summer Student Research Program, was funded by the CMDNJ Foundation. Since then, the College-wide program in humanities has been decentralized, and programs are left to the discretion of the individual schools. Mr. Klein is a member of the Class of 1983, New Jersey Medical School, CMDNJ. Correspondence may be directed to him at 28 E. Park Ave., East Orange, N.J. 07017.

Twenty-six of the forty plus members of the Faculty Council were interviewed. Of these, fifteen actively were providing patient care in addition to their teaching and/or administrative activities (designated PC). Eleven were basic science faculty primarily engaged in research or were pathologists with no patient care or clinical teaching responsibilities (designated NPC).

Thirteen of the fifteen respondents involved in patient care believed there was an important role for the humanities in a medical education (See table). The other two patient-care oriented individuals felt the term "humanities" to be so undefinable as to prevent their answering the question. Of the non-patient care respondents, only one felt the humanities had an important role, two felt the role was to be determined by each individual's needs and experiences, and eight of the eleven felt the proper exposure for humanities to be during the student's pre-medical education.

Table 1
Nature of the Role of Humanities
in Medical Education

	Total	PC	NPC
Important	14	13	1
Individual	2	0	2
Pre-medical	8	0	8
No answer	2	2	0

PC = involved in patient care activities in addition to other responsibilities.

NPC = not involved in patient care activities.

Other survey questions probed the group opinion on such diverse matters as whether the school should shape the opinions of its students, facilitate the students becoming active and responsible community members, and teach students how to teach patients about their health. Responses were mostly positive in all of the above.

Knowledge of health care humanities teaching at NJMS was tested and showed that most faculty who were not directly in contact with a particular program, such as "Ethics for Lunch" or the "Practice of Medicine" Clerkship, were

unaware of existing efforts.

The physicians surveyed were asked what, in retrospect, they would have liked to have been exposed to while in medical school that they later had to learn for themselves. The responses centered upon the need to think of patients as whole people, within their environments, and to approach their care in a holistic and/or humanistic manner.

All interviewees were asked to describe the ethical questions every medical student should face prior to dealing with the real life experience. Most (twenty-one) of the respondents answered with one or more of the issues normally thought of as part of medical or professional ethics. Additionally, seven of the physicians felt it was important for every student to consider his or her own identity or role as a "care-giver."

Each respondent was asked to define "health," and to compare the definition with his/her opinion of the role of humanities in medical education in light of education for a health care role. They also were asked whether students with whom they came in contact at NJMS had, in their opinion, "an awareness of the types of human values issues we've been discussing."

Finally, each respondent was asked what type of program he/she would design to teach some of these values. The responses favored an integrative approach, as has also been proposed by Siegler, which would introduce and continually integrate discussion of human values with all patient care experiences, consistent with William Osler's "bedside teaching."³ However, this does not answer the questions raised by the attitude of the basic science faculty, with whom the students spend the majority of their time during the first two years of medical education. The need to "raise the consciousness" of some of the faculty was noted by some of the respondents, and several program models were suggested.

Reference

- Siegler M: A legacy of Osler: Teaching clinical ethics at the bedside. *JAMA* 239: 951-956, 1978.

Trustees' Minutes April 12, 1981

A regular meeting of the Board of Trustees was held on Sunday, April 12, at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

MSNJ Representation at Hospital Staff Meetings . . . Agreed that effective with the 1981-1982 administration a plan be developed whereby an officer or trustee represent MSNJ at quarterly staff meetings of New Jersey's acute care hospitals for the purpose of providing an avenue for communicating the Society's message to physicians who have not joined the Society.

Professional Liability Insurance . . . Received a report from Dr. Todd on the Medical Inter-Insurance Exchange of New Jersey's attitude regarding the proposal of Health Care Insurance Exchange (the New Jersey Hospital Association's malpractice carrier) to write claims-made insurance for physicians, which indicated that MIE has a responsibility to make sure fiscal integrity is preserved and does not want to make political decisions based on competition. No efforts to retaliate by offering insurance coverage to other health field personnel and/or extending coverage to individuals outside the health field are planned. It is conceivable that in the future new members of the Exchange will not be required to contribute to the fund and some of the original seed money can be paid back to the insureds.

Executive Committee Meeting with Blue Shield Representatives . . . Received the following report of the meeting of MSNJ's Executive Committee with Blue Shield representatives:

1. Current Procedure Terminology—4th Edition (CPT-IV)—Blue Shield will be converting Plan Coding to Current Procedure Terminology—4th Edition. This concept soundly has been approved by the AMA House of Delegates, and the Executive Committee indicated that the Society is in favor of the conversion. The President will appoint a technical advisory committee to assist in implementation.

2. Paperless Processing—The Plan is beginning to utilize paperless processing techniques (CRT), and requested that an advisory committee be established. Such a mechanism would improve cash flow

to physicians. It was decided that the committee to be appointed by the President could consider both issues.

3. Surgical Assistant—Pursuant to the suggestion of the Medical Society of New Jersey, the Plan filed a request with the Insurance Department to provide for payments to assistant surgeons under Experience Rated Groups. The Department denied the request. Blue Shield has filed suit on the basis of this inconsistent and discriminatory action.

4. Multispecialty Advisory Committee—The Plan has contacted some 22 New Jersey specialty societies asking them to appoint a representative to a Multispecialty Advisory Committee. About ten societies have complied. There have been no refusals.

5. Legislation—The Plan requested Society approval of a bill that would declare radiology a medical service covered under Blue Shield. Since this has been the recorded position of the Society, support was assured.

6. Inpatient Radiology—A tentative agreement has been reached resolving the litigation between the radiologists and Blue Cross.

7. Application of Service Benefits in Major Medical Coverage Situations—The Plan will continue to pay major medical coverage when the individual is eligible for service benefits. A special study has been devised to study the impact this may have on rates. The report from this study will be discussed in the Fall.

8. Physiatry Service—A member of the Union County Medical Society raised a question regarding compensation for a certain procedure. This procedure is recognized as a hospital service and is reimbursed under Blue Cross. The physician will be so advised.

Dues' Collection—1981 . . . Noted that: (1) as of March 31, MSNJ has received dues for 6,360 regular members (334 below the comparable point in 1980) and (2) as of April 10, 73 county society delegates and/or alternates had not paid their dues.

MSNJ Financial Statements . . . Received copies of balance sheets as of February 28 and March 31 and statements of revenue and expenses and analyses of expenses for the nine months ending February 28 and ten months ending March 31.

Litigation Reports . . . Noted the following:

1. A hearing date has not been set for the litigation involving the State Board of Medical Examiners and Dr. Driggs.

2. The matter of deductibility of subordinated loan payments is being handled by the Chief of Technical Advisory at the IRS office in Washington. Mr. Heaney, Tax Counsel, has conferred with him and it is expected a decision will be reached before the Annual Meeting.

Actions of State Board of Medical Examiners . . . Noted the following actions of the State Board of Medical Examiners at its meeting on March 11, 1981:

1. Requested the Medical Society of New Jersey to forward to the Secretary of the State Board the names of all physicians enrolled in the impaired physicians program. (It is believed that it would be inappropriate for the Society to turn over lists or reports on physicians who were not referred into the program by the State Board. On the advice of Mr. Maressa, the Committee on Impaired Physicians has suggested that the State Board appoint a subcommittee to meet with it to resolve the issue.)

2. Denied a request by medical students to serve as "scribes" for physicians' orders. (This reaffirms the State Board's ruling that has been in effect.)

3. Developed a rule proposal for publication to permit New Jersey hospitals to take seventh and eighth semester foreign medical students into clinical experience programs. (The proposal is still pending. Before developing an educational program, individual physicians were advised first to get clearance from the State Board.)

4. Ruled that chiropractors can make certain judgments as to the physical condition of patients, and consequently can authorize a student to be excused from taking physical education classes in grammar or high school.

5. Responded to a request from a physician for an ethical opinion as to whether the doctor should advise the children of the patient that their father suffers from an hereditary disorder. Suggested the doctor fully research the disease to determine if it is genetic. If not, it would be inappropriate to breach the physician-patient relationship.

6. Voted to approve a bill declaring that podiatrists should be considered the equivalent of other hospital staff members under hospital bylaws (A-3060). (Recommended position of the Council on Legislation on the bill is active opposition.)

7. Voted to take no action on a bill to make excessive absenteeism a cause for removal from the Board (S-1670 and A-2359).

8. Voted to oppose a bill requiring that one-fourth to one-third of State Board members be public members, and to provide per diems for all Board members (S-1668 and A-2370). (Recommended position of the Council on Legislation on this bill is **active opposition**.)

Supreme Court Subpanels—Rule 4:21

... Noted that the Supreme Court Committee will meet to consider certain revisions to the 4:21 panels suggested by the State Bar Association. It does not appear that the revisions will jeopardize the physician's role in the panels or have an adverse impact from the defendant's viewpoint.

Dues' Exemption ... Noted that because of the growing number of dues-exempt members under the age of 70, requests for physicians to be placed in that category are being reviewed. Mercer County had appealed the determination not to grant dues' exemption to four physicians, one a career officer in the military, three in residency programs. The Mercer County Medical Society has advised the Board that it is in agreement that the physician in the employ of the military is not eligible for dues' exemption; however, since no judgment has been made concerning the financial position of the three physicians in residency programs, the County will continue to waive dues and will pay the regular dues to the State Society.

Excessive Fee Regulation ... Noted that the State Board of Medical Examiners formally proposed its rule on unconscionable excessive fees for professional services. The Society's action on the ruling will depend on the final structure of the proposal when it is adopted by the Board.

Committee on Finance and Budget ... Approved the following recommendations from the Committee on Finance and Budget:

(1) That the budget for the fiscal year beginning June 1, 1981, and ending May 31, 1982, in the amount of \$2,252,000, with \$1,796,000 to be raised through member assessments, be adopted.

(2) That the 1982 assessment be set at \$245 per regular dues-paying member.

(3) That the 1982 assessment be set at \$25 per member for affiliate and associate members.

(4) That there be an assessment for 1982 of \$25 per member for licensed residents provided the individual is in a residency program entered upon within a reasonable time after his or her graduation from medical school.

(5) That the 1982 assessment be set at \$5 per student for medical students.

... Concerning the recommendation that a special assessment of \$20 be levied for the New Jersey Foundation for Health Care Evaluation, it was directed that a committee composed of the Executive Committee, MSNJ's Administrative Staff and other concerned parties be established to investigate the function of the New Jersey Foundation for Health Care Evaluation with regard to its past and future performance and submit a report to the Board on May 15.

Scientific Section on Otolaryngology

Approved a request to add "Head and Neck Surgery" as part of the name of the Scientific Section on Otolaryngology, reflecting the national trend (American Academy of Otolaryngology—Head and Neck Surgery and the American Council of Otolaryngology—Head and Neck Surgery).

Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

Reference has been made here to the legislation proposed by Representative Richard Gephardt of Missouri. His bill (formerly the Gephardt-Stockman bill, before Mr. Stockman took the helm at OMB) is one of the pro-competition efforts patterned after Professor Enthoven's consumer choice form of national health insurance. In a review of national health insurance plans, *AM News* states that the Board of Trustees and Council on Legislation of the AMA strongly object to the radical restructuring contemplated by the Gephardt bill (HR 850).¹ The bill would allow the offering of health insurance plans through *any* individual or entity while removing state-imposed restrictions on the provision of care and insurance. Plan sponsors would negotiate with providers (including physicians), and care would be furnished through closed arrangements. *Corporations could become directly involved in providing care.* The Secretary of HHS would have broad authority to issue regulations concerning health care and insurance. Not only would

there be new and nationwide regulations to be followed, but a combined government-corporate effort to control practice and insurance would be put in place. Relief from governmental regulations would not ensue. It was not too many years ago that the phrase: "corporate practice of medicine" rang through the halls of AMA and MSNJ gatherings, as a kind of alarm against outside influences.

A *New York Times* article, in the business section, indicates how much corporate practice is creeping upon us.² Humana, Inc., of Louisville, Kentucky operates 91 acute care hospitals around the country, with billing controlled at its central offices. Humana had profits of \$64 million last year, on revenues over \$1 billion. It overtook and absorbed American Mediacorp a few years ago, and is now looking to take over Brookwood Health Services of Alabama.

There are profit-making organizations operating "emergency rooms," same-day surgical centers, nursing homes, and other medical enterprises around the nation. While such endeavors are in the tradition of American free enterprise, I'm not sure that is what most of our colleagues have in mind when "competition vs. regulation" is discussed. Government regulations are repugnant in many ways, but policies and procedures of a billion dollar corporate enterprise could prove just as stifling to the traditional practice of medicine. There are problems with local state health and insurance regulations, but the climate may not be improved if the rules of practice *and* insurance are made in Washington and promulgated from Louisville or Alabama. The efforts to control medical practice and how it is paid for will go on, and your vigilance should not relax because of an apparent change in government philosophy.

What is best for the patient and the public in general should be kept in mind. The large profit-making business will have no interest in the unprofitable cases. These will wind up where they always have in the large, inner-city hospitals with burdensome deficits, and in the long-term "warehousing" facilities. This not only will perpetuate the "two-tier" health care system, but will add the corporation layer. It even could be regarded as the epitome of rationing of care, masquerading under the label of "resource allocation."

¹*American Medical News*, April 17, 1981

²*The New York Times*, April 17, 1981

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule contains:

Pentylene-tetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCL	25 mg.
L-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine HCL	3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Won S. Cho, M.D., 1303 Midmeadow Road, Towson, MD 21204. Korea University, 1963. Board eligible. Group, partnership, or solo. Available on one month's notice.

Parvin Javadi, M.D., P.O. Box 50, Bradford, PA 16701. Pahlavi Medical School (Iran) 1964. Board eligible. Group, partnership, solo, academic. Available.

CARDIOLOGY—Lawrence J. Gessman, M.D., 21 Sabine Avenue, Narberth, PA 19072. University of Pennsylvania 1974. Board certified. Group, partnership (preferably with cardiac catheterization). Available.

G. R. Kolluru, M.D., 914 South Avenue, Apt. E-33, Secane, PA 19018. Andhra (India) 1973. Board certified (IM). Group, partnership, solo. Available July 1981.

FAMILY MEDICINE—Robin O. Winter, M.D., Hunterdon Medical Center, Flemington, NJ 08822. Einstein 1978. Board eligible. Group, partnership, solo. Available August/September 1981.

Allan P. Olivieri, M.D., 120 West 80th Street, New York, NY 10024. Cornell 1976. Board certified. Group, partnership, hospital affiliate (full time). Available.

Louis Verardo, M.D., 21 Walnut Road, Apt. 1—2A, Glen Cove, NY 11542. University of Bologna (Italy) 1978. Board eligible. Group (private or hospital-sponsored), preferably with opportunities for medical school/residency affiliation (for teaching purposes). Available August 1981.

INTERNAL MEDICINE—William C. Zuck, Jr., M.D., 1769 Raleigh Court West, Apt. 25-B, Ocean, NJ 07712. Graz (Austria) 1977. Board eligible. Solo or group. Available July 1981.

Sanford L. Taffet, M.D., 160 East Hartsdale Avenue, Hartsdale, NY 10530. NYU 1976. Subspecialty, gastroenterology. Board certified. Partnership or group. Available July 1981.

Arvind M. Mehta M.D., #1-F. Bldg. 1, 40 Prospect Avenue, Norwalk, CT 06850. M.S. University (India) 1975. Subspecialty, cardiology. Board eligible. Group, partnership or multi-specialty group. Available July 1981.

John Aylward, M.D., 86 East Almira Street, Bloomfield, NJ 07003. CMDNJ 1978. Group or partnership. Available July 1981.

Vijay K. Nellore, M.D., 134 North Street, Bayonne, NJ 07002. Osmania (India) 1973. Solo, group, or institutional. Available July 1981.

Mark Isserman, M.D., 103 Dennis Avenue, Port Allegany, PA 16743. Jefferson 1977.

Board certified. Solo, partnership, group. Available July 1981.

Prabhakar N. Vaidya, M.D., 7752 Montgomery Road, Apt. 81, Cincinnati, OH 45236. Seth G.S. Medical College (India) 1969. Board certified. Single or multi-specialty group, partnership, or hospital-based. Available.

Lakhu Janimal Rohra, M.D., 86-19 Elmhurst Avenue, Apt. 3-E, Elmhurst, New York 11373. Baroda (India). Board eligible. Solo, associate, group. Available July 1981.

M. A. Menon, M.D., 355 Crale Boulevard, #202, Melvindale, MI 48122. Armed Forces Medical College (India) 1974. Subspecialty, gastroenterology. Board certified. Group, solo. Available July 1981.

Bankim D. Shah, M.D., 100 Hospital Plaza, #705, Paterson, NJ 07503. T.N. Medical (India) 1974. Group, partnership, solo. Available July 1981.

Rakesh Anand, M.D., 412 Maryland Avenue, Apt. 3-C, Staten Island, NY 10305. Medical Institute, New Delhi (India) 1973. Board certified. Solo, partnership, group. Available on one to two months' notice.

Marzie T. Nejad, M.D., 2200 Benjamin Franklin Parkway, Apt. S-1105, Philadelphia, PA 19130. Tehran University (Iran) 1969. Subspecialty, nephrology. Board eligible. Hospital-based, partnership, group. Available July 1981.

NUCLEAR MEDICINE—M. I. Straub, M.D., 254 Frances Street, Teaneck, NJ 07666. Semmelweis (Hungary). Special interest, diagnostic radiology. Board eligible. Available July 1981.

OBSTETRICS/GYNECOLOGY—F. Adibi, M.D., 84 Skyline Drive, Chalfont, PA 18914. Tehran (Iran) 1967. Board certified. Group/partnership. Available.

Dilipkumar G. Patel, M.D., 72 Duke Street, New Brunswick, NJ 08901. Baroda (India) 1974. Board eligible. Group, associate, solo, hospital. Available July 1981.

Mohammed M. Mohiuddin, M.D., 215 Locksley Road, Syracuse, NY 13224. Osmania (India) 1973. Board eligible. Any type practice except academic position. Available July 1981.

Mridu B. Agarwal, M.D., 318 East 15th Street, Apt. 6-A, New York, NY 10003. Lady Hardinge (India) 1971. Solo, group, or partnership. Available July 1981.

Jung Fu Chen, M.D., P.O. Box 218, Petersburg, WV 26847. National Taiwan University 1956. Board eligible. Partnership, solo. Available.

OCCUPATIONAL MEDICINE—Louis Z. Fauteux, Jr., M.D., 294 Carlton Avenue, Piscataway, NJ 08854. Georgetown 1947. Board certified (IM). Board eligible. (OM). Industrial. Available.

PATHOLOGY—Alexander J. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified (AP and CP). Any type practice including institutional. Available.

Aruna Kumar, M.D., 6223-B Newport Avenue, Norfolk, VA 23505. J.L.N. Medical (India) 1972. Board eligible (AP/CP).

A peripheral vasodilator
for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Group, solo, or partnership. Available July 1981.

PEDIATRICS—Anil G. Pradhan, M.D., 118 Grove Park, Fort Dix, NJ 08640. Bombay (India) 1972. Board certified. Solo, partnership, associate, group. Available.

Rajendra C. Parikh, M.D., 77-07 Woodside Avenue, Apt. 3-A, Elmhurst, NY 11373. Baroda (India) 1975. Board eligible. Group, partnership, solo, or institutional. Available June 1981.

Shara J. Doshi, M.D., 304 Fir Street, Raceland, Louisiana 70394. B.J. Medical (India) 1969. Board eligible. Solo, group, partnership, clinic. Available.

Fe C. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified. Any type practice. Available.

Yogesh J. Pandya, M.D., 24 Paerdegas—15th Street, Brooklyn, NY 11236. Baroda (India) 1973. Board eligible. Solo, group, partnership, hospital-based. Available.

Susheela Raghunathan, M.D., 9 Weston Place, East Brunswick, NJ 08816. India 1973. Board eligible. Group, institutional, clinic, emergency room, or house staff, student health center. Available July 1981.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379. Shah (India) 1969. General practice and rehabilitation medicine. Available on three months' notice.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available July 1981.

Thomas A. Giangrosso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available July 1981.

SURGERY, GENERAL—Mohammad Qubair, M.D., 2694 South Hoyt Street, Lakewood, CO 80227. Pakistan 1970. Board eligible. Partnership, solo. Available July 1981.

Jin-Young Lee, M.D., St. Mary's Hospital, 56 Franklin Street, Waterbury, CT 06702. Seoul National (Korea) 1971. Board eligible. Group, partnership, solo. Available July 1981.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available July 1981.

S. R. Bajina, M.D., E1501, Park Towne Place, 2200 Benjamin Franklin Parkway, Philadelphia, PA 19130. Special interest—gastrointestinal endoscopy. Board certified. Solo, group, institutional-based. Available.

Rajendra M. Agarwal, M.D., 318 East 15th Street, New York, NY 10003. King George's (India) 1968. Solo, group, or partnership. Available July 1981.

P. Joshua Mammen, M.D., 404 West 51st Street, Apt. 2-B, New York, NY 10019. Trivandrum (India) 1970. Board eligible. Group, partnership, solo. Available July 1981.

B. Paulauskas, M.D., Route 1, Box 273-M, Lake Placid, FL 33852. Lithuania 1972. Special interest, vascular surgery. Board eligible. Group, partnership, solo. Available.

Kong Hua L. Go, M.D., 605 Louisiana Avenue, Apt. 17-A, Brooklyn, NY 11239. Far Eastern (Philippines) 1973. Board eligible. Any type practice. Available.

Job S. Kakkasseril, M.D., 3194 McGill Lane, Cincinnati, OH 45239. Pradesh (India) 1972. Board eligible. Group, solo, or partnership. Available July 1981.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available July 1981.

Inder J. Singh, M.D., WCMC #1-C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available July 1981.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available July 1981.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available July 1981.

UROLOGY—Harvey Schoenbrun, M.D., 1249 Park Avenue, Apt. 14-A, New York, NY 10029. Pittsburgh 1976. Board eligible. Group, partnership. Available July 1981.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available June 1981.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available July 1981.

Robert D. Zimmerman, M.D., 206 Friar Lane, Clifton, NJ 07013. Chicago Rush-Presbyterian. Board eligible. Partnership, solo, group. Available July 1981.

Talluri Balaji, M.D., 1926 West Harrison St., Apt. 916, Chicago, IL 60612. Osmania (India) 1973. Solo. Available July 1982.

Mahendra S. Shah, M.D., 62 Forsythia Lane, Paramus, NJ 07652. Baroda (India) 1968. Board certified. Group or partnership. Available.

CMDNJ Notes

**Stanley S. Bergen, Jr., M.D.
President**

Thanks to recent grants totaling nearly \$900,000 from three separate foundations, medical education programs will be expanded by CMDNJ.

At the CMDNJ campus in Newark, an Ambulatory Rehabilitation Medicine Center will be made possible by a \$325,544 grant from the Dr. Scholl Foundation and a \$60,000 grant from the Fannie E. Rippel Foundation.

A grant of \$487,305 from the Robert Wood Johnson Foundation will provide support over a three-year period to add a planning and management capability needed to expand clinical education and patient care programs at Middlesex General Hospital, New Brunswick, the primary teaching hospital of CMDNJ-Rutgers Medical School, and at other community hospital teaching affiliates.

Both grants for the Ambulatory Rehabilitation Medicine Center in Newark are being administered by the Foundation of CMDNJ, a non-profit corporation which is committed to the advancement and support of the College. Foundation funding enhances existing programs in education, research and service at CMDNJ, and promotes innovative ventures in the health sciences.

Funds from the Rippel Foundation grant will be used to help remodel part of the CMDNJ Martland Building to house the Rehabilitation Center, and the Dr. Scholl Foundation funds will go toward establishing the Center over a three-year period.

The Center will be the only one of its kind in the city of Newark to handle the disabilities of those patients discharged from hospital and other chronically ill residents who have been forced to go elsewhere for treatment. Among the patients to be treated at the Center will be amputees, arthritics, stroke victims and sufferers of low back pain.

A coordinated team approach, stressing the multidisciplinary integration of rehabilitation medicine specialties and other services will be utilized for total patient care at the Center. The team concept embraces patient care needs, medical education and creates the opportunity to accomplish research in an environment that will provide for direct professional communication and interaction with the patient in order to develop specific and relevant therapies.

The team will consist of the director

physician-specialist in rehabilitation therapy, a paramedical specialist expert in one of the diverse therapies to be undertaken and the patient who, in physical and emotional interaction with physician and therapist, will become the integral and central focus of the team. Through this team approach, it is envisioned that the Center can serve as a national model.

The Center will provide the setting for clinical teaching of some 590 medical students and 544 residents on the Newark campus, and it will provide the College with a strong and diversified department of rehabilitation medicine.

The opening of the College's \$200-million Newark campus in 1977 and particularly the opening of College Hospital in 1979 have intensified the need that already existed for such a center, because none of the general hospitals in the area has a comprehensive rehabilitation medicine center.

CLINICAL EDUCATION EXPANSION

The Robert Wood Johnson Foundation, headquartered in Princeton, is the nation's largest health care philanthropy. In the past nine years the Foundation has awarded some \$400 million for the improvement of health care in the United States.

In addition to the clinical education of students at CMDNJ-Rutgers Medical School, programs for postgraduate physicians in affiliated hospitals will be augmented through the Robert Wood Johnson grant. Currently, there are 351 physicians in residency training at 15 affiliated hospitals under the auspices of the school.

Funds from the grant have been earmarked for four areas; development of the ambulatory care program at Middlesex General Hospital; development of educational programs at affiliate hospitals; analysis of patient referral within the affiliated hospital network; and identification and development of new opportunities to enhance patient care, teaching and research at all affiliates of the school.

From the school's programs for present and future physicians will come many of the doctors who will be establishing their practices in New Jersey. Therefore, it is incumbent on CMDNJ to provide them with the best opportunities possible, and the Robert Wood Johnson grant will help provide CMDNJ with the means to accomplish this goal.

ATTENTION

Biennial registration applications for physicians licensed to practice medicine and surgery in New Jersey were mailed early in May. The applications are for the period July 1, 1981 through June 30, 1983. If you have a question please communicate with the State Board of Medical Examiners, 28 West State Street, Trenton 08608—telephone (609) 292-4843.

Be sure your application is completed and returned before the expiration date—June 30, 1981.

CME CALENDAR

(Contact Sponsoring Organization for Information)

CARDIOLOGY

Aug.

- 14 **Peripheral Vascular Disease**
11 a.m.—South Bergen Hospital,
Hasbrouck Heights
(AMNJ)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

July

- 14 **Pulmonary Diseases**
8-9:30 p.m.—Shore Memorial Hospital,
Somers Point
(Shore Memorial Hospital and AMNJ)

Aug.

- 11 **Newer Antibiotics**
8-9:30 p.m.—Shore Memorial Hospital,
Somers Point
(Shore Memorial Hospital and AMNJ)
- 14 **Peripheral Vascular Disease**
11 a.m.—South Bergen Hospital,
Hasbrouck Heights
(AMNJ)

NEUROLOGY/PSYCHIATRY

July

- 1 **Ongoing Child Psychiatry—**
- 8 **Case Conference and Lecture**
- 15 8:30-10:30 a.m.—Trenton
22 **Psychiatric Hospital**
29 (Trenton Psychiatric Hospital and
AMNJ)
- 2 **Psychiatric Aspects of Disability**
- 9 **ECT in Treating Acute Psychosis**
- 16 **Violent Patients and Vicissitudes of Separation**
- 23 **Psychiatry Resident Shortage and Training Issues**
- 30 **Group Therapy**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(Carrier Foundation and AMNJ)
- 14 **Medication Treatment Refusal and the Right to Treatment**
9 a.m.-4 p.m.—Carrier Foundation,
Belle Mead
(Carrier Foundation and AMNJ)
- 16 **Electromyography**
7:30-9 a.m.—West Jersey Hospital,
Voorhees
(West Jersey Hospital, Dept. of Surgery)

Aug.

- 5 **Ongoing Child Psychiatry—Case**
- 12 **Conference and Lecture**
- 19 8:30-10:30 a.m.—Trenton Psychiatric
26 **Hospital**
(Trenton Psychiatric Hospital and
AMNJ)
- 8 **Transactional Analysis**
- 13 **Gonadal Steroids for Chronic Endogenous Depression**
- 20 **Placebo Response**
- 23 **Homosexuality, Transvestism and Transsexualism**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(Carrier Foundation and AMNJ)

OBITUARIES

Dr. Joseph W. Crowley

At the grand age of 83, Joseph W. Crowley, M.D., formerly of Pennsauken, died on March 3 after a long illness. A native of Philadelphia, Dr. Crowley was graduated from the University of Pennsylvania School of Medicine in 1923 and established a general practice in Camden which he maintained for 45 years until poor health forced his retirement. He had been affiliated with the Cooper Medical Center in Camden.

Dr. Cornelius V. DeBiao

One of Bergen County's senior members, Cornelius V. DeBiao, M.D., of Rutherford, died on March 29. A native of New York City, Dr. DeBiao was graduated from the Royal College of Physicians and Surgeons in Edinburgh in 1935 and after internship came to Rutherford to establish a practice in general medicine. He had been on the staff at Hackensack Hospital and was on the faculty at Fairleigh Dickinson University in Rutherford. During World War II, Dr. DeBiao served with the medical department of the AUS. He was 77 years old at the time of his death.

Dr. John W. Fessman, III

At the untimely age of 49, John W. Fessman, III, M.D., a member of the Camden County component and a general practitioner in Waretown, died on March 30 at South Amboy Hospital. A native of Camden, Dr. Fessman was graduated from Hahnemann Medical College in 1957 and took over his father's general practice in Runnemede in 1958. In 1972 he moved to Long Beach Island and established a practice in Waretown. He was a member of the staff at the Southern Ocean County Hospital and formerly had been associated with St. Agnes Hospital in Philadelphia.

Dr. F. Albert Graeter

On April 8, F. Albert Graeter, M.D., formerly chief of anesthesiology and a past president of the medical staff at

Passaic General Hospital, died there. Born in France, Dr. Graeter came to the United States as an infant and earned his medical degree at Georgetown University Medical School in 1935. He pursued graduate training in anesthesiology at Gallinger Hospital in Washington, D.C. and at Passaic General. During World War II, Dr. Graeter served in the medical department of the AUS, attaining the rank of major. He was 72 years old at the time of his death.

Dr. Arthur J. Greenleaf

One of Cape May County's senior members, Arthur J. Greenleaf, M.D., formerly of Wildwood and Cape May, died on March 26. A native of Pennsylvania, Dr. Greenleaf was graduated from the University of Pittsburgh School of Medicine in 1922 and established a practice in dermatology in Mountville, Pennsylvania until 1960 when he moved to Cape May, transferring his membership from the Lancaster County (Pennsylvania) Medical Society to our Cape May component. Before coming to New Jersey he had been on the staff of the Lancaster General Hospital and was president of his county medical society there. Since moving to New Jersey he had been associated with the Burdette-Tomlin Memorial Hospital in Cape May Court House. Dr. Greenleaf, who had been living in retirement at Meadow Lakes in Hightstown, was 91 years old at the time of his death.

Dr. Robert K. Harvey

Robert K. Harvey, M.D., a general practitioner in Kearny for 45 years, died at John F. Kennedy Medical Center in Edison on April 2. A native of New York, born in 1907, and a graduate of New York University, class of 1935, Dr. Harvey had been a member of the staff at the West Hudson Hospital, Kearny, where he served as chief of the first surgical service until his retirement in 1978. He was a Fellow of the American Academy of Family Practice. During World War II Dr. Harvey served with the medical department of the AUS in

England. He was active in community affairs and was for many years police surgeon for the town of Kearny.

Dr. George A. Hoffman

On March 30, George A. Hoffman, M.D., a member of our Bergen County component, died at his home in Hackensack. A native of Jersey City, born in 1921, Dr. Hoffman earned his medical degree from Long Island College of Medicine in 1945 and practiced general medicine for many years in Leonia and later in Franklin Lakes. He was Director of Emergency Medicine at Bergen Pines County Hospital and had been affiliated also with the Valley Hospital in Ridgewood. During World War II, Dr. Hoffman saw service in the medical department of the AUS.

Dr. Richard R. Lamb

A member of our Salem County component, Richard R. Lamb, M.D., died at Underwood-Memorial Hospital in Woodbury on April 7. A native of New York City, born in 1907, Dr. Lamb earned his medical degree from Temple University School of Medicine in 1930. His early medical career was spent as a general practitioner in New York City, and after six years as a flight surgeon with the United States Air Force serving in North Africa and Europe, he came to Philadelphia to accept a position as director of education at Philadelphia General Hospital and to pursue a residency in anesthesiology at the University of Pennsylvania Hospital. For fifteen years he served as chief of anesthesiology at Mercer Medical Center (Trenton) and more recently held the same position at Salem County Memorial Hospital.

Dr. Elroy Pasternack

Elroy Pasternack, M.D., a senior member of the Passaic County component, died at his home on March 27. Born in Passaic in 1909, Dr. Pasternack was graduated from the Medical School of the University of Indiana in 1936 and after completing a residency at Bellevue

Hospital, New York, pursued a career in the practice of anesthesiology. He had been affiliated with Hasbrouck Heights Hospital and the Barnert Memorial Hospital in Paterson. During World War II, Dr. Pasternack served in the medical department of the AUS.

Dr. Samuel Schulsinger

At the grand age of 91, Samuel Schulsinger, M.D., a member of the Essex County component, died at his home in New York City on January 7. A native of Poland, Dr. Schulsinger earned his medical degree from the University of Berne in Switzerland in 1918 and emigrated to the United States in the early 1920s. He pursued a career in ophthalmology, becoming board certified in that specialty, and practiced in Newark until retirement in 1977. Dr. Schulsinger had been affiliated with the Beth Israel Medical Center in Newark.

Dr. William Stein

On April 2, a senior member of our Middlesex County component, William Stein, M.D., of New Brunswick, died.

Born in Russia, Dr. Stein emigrated to the United States as a child and earned his medical degree at the University of Syracuse School of Medicine, class of 1931. He pursued graduate training in cardiology and physical disability, becoming board certified in both specialties. He was a Fellow of the American College of Chest Physicians and of the American College of Physicians. Dr. Stein had been affiliated with St. Peter's and Middlesex General Hospitals in New Brunswick. During World War II, he served with the medical department of the AUS. He was 74 years old at the time of his death.

Dr. Max H. Teichholz

Max H. Teichholz, M.D., a past president and former medical director of Beth Israel Medical Center in Newark, died at Mt. Sinai Hospital in New York on March 28. Born in Passaic in 1912, Dr. Teichholz earned his medical degree from the Cincinnati Eclectic Medical College in 1938 and returned to his home town to practice internal medicine and cardiology until two years ago when he retired and moved to Verona. Dr.

Teichholz was also on the staff at Passaic General and St. Mary's Hospitals in Passaic and was coordinator of the Passaic Tri-Hospital Home Care Program. During World War II, Dr. Teichholz served with the medical department of the AUS.

Dr. Henry V. Weinert

Henry V. Weinert, M.D., past president of the medical staff at St. Mary's Hospital in Passaic, died there on April 6. A native of Jersey City, born in 1898, Dr. Weinert received his medical degree from the University of Maryland's School of Medicine in 1923 and pursued a career in surgery, earning fellowship in the American College of Surgeons. He was a former director of surgery and of the tumor clinic at St. Mary's Hospital. Dr. Weinert was instrumental in establishing the first tissue committee of its kind in the country which served as a forerunner for tissue committees in all American hospitals. A committee chaired by Dr. Weinert established regulations for the improvement of standards of surgical care which ultimately were adopted by the Joint Commission on the Accreditation of Hospitals.

BOOK REVIEW

Biofeedback—Issues in Treatment Assessment

Bette Runck. Rockville, Maryland, National Institute of Mental Health, USDH, 1980. Pp. 99. (No price given)

Of the recent contributions of behavioral science to the practice of medicine, biofeedback appears to have the most promise. The techniques are straightforward and relatively easy to learn. The equipment is inexpensive and the course of treatment is short when contrasted to other behavioral interventions. Over the past decade numerous reports have appeared attesting to the utilization of biofeedback either as the primary or as an auxiliary therapeutic technique in the treatment of a number of pathologic

conditions particularly those relating to disturbed autonomic functions.

As is often the case, the early reports of success were overly optimistic and at present, a considered reappraisal is under way.

One recent contribution to that effort appears as one of a group of science reports issued by the National Institute of Mental Health. The publication titled *Biofeedback Issues in Treatment Assessment* first presents a brief history of the development of biofeedback techniques followed by a consideration of the possible mechanisms underlying its effectiveness. There then follows an assessment of biofeedback as a treatment and lastly, an evaluation of its specific applications.

This is the sort of straightforward approach which ordinarily appeals to the practicing physician but unfortunately in the case of this publication, the usually laudatory characteristics of brevity, simplicity and evenhandedness lead more to confusion than to clarity. There is too little detail to permit the reader to make up his own mind concerning the relative value of biofeedback and so little guidance concerning the weight of expert opinion that the value of biofeedback as a therapeutic tool is left unresolved. For this reason it provides little value to the reader interested in the practical aspects of patient care.

Irwin Pollack, M.D.

REDWOOD DECKS

Call Mike
The Fancy Deck Builder
(201) 595-6263

MOVING YOUR OFFICE

If you're planning on moving your office in or out of the North Jersey area, HEMMINGS MOVING & STORAGE CO. can be of service. We've been offering prompt, efficient, courteous service since 1924. Hourly and weight rates available. We can also coordinate the move of your residence along with your practice.

For more information, call or write:

John Hemmings
Hemmings Moving & Storage Co.
P.O. Box 596, Rt. 24W
Chester, NJ 07930
201-876-4226
201-526-6463



Mayflower

LEASE OFFICE

Ophthalmologist desired to lease office space in a new medical building. Excellent promise for thriving ophthalmology practice; suitable for initial location or as a second office. Please contact East Gate Medical Building, 609-428-4775.

MAGNIFICENT ESTATE



Elegant mansion gracefully set on 2 plus Acres w/panoramic view, professionally decorated thruout. Dramatic Reception Hall with sweeping Antebellum staircase leads to 20 x 40 Living Rm w/fireplace, Dining Rm, Library, Powder Rm, Cheerful Solarium and more! New Gas 4 Zone heating system w/heat pumps and 4 Zone Central Air results in low utility costs. Added Bonus—Carriage House w/3 Rm Apartment and 3 Car Garage w/electric door. \$450,000.

Located in North Caldwell, N.J., a prestigious community just 20 minutes to Lincoln Tunnel and George Washington Bridge.

Close to Rts. 280, 287, 80, 23, 46, 10 with convenient Bus and Train Transportation.

For Additional Information Call Broker
LEON REAL ESTATE CO. (201) 228-5503

FOR SALE

Gracious Georgian colonial set back 200' from road, sweeping circular drive. The 13 x 16 foyer will impress you a great deal along with the 17 x 19 library (with bar, built-in display cabinets), 40' living room and country dining room (all with fireplaces). The warm, cozy breakfast room is adjacent to the finished equipped kitchen. The solarium is a real charmer of total glass and mirrors, plus bar. 2-1/2 baths complete the downstairs. Four bedrooms and 2 full baths, ample closets and mirrors galore. House heavily insulated and designed inside and out for low maintenance. Permit exists for professional use on this 2.5 acres. Parking space no problem. Phone for an appointment.

(609) 924-7026 or 395-1300

OFFICE SPACE FOR RENT

Office space available next to a Dental Office in a new professional building located on Main Street, Manville, New Jersey. Somerset Medical Center is five minutes away. A town of 14,000 plus, presents an unusual opportunity for an immediately successful practice.

Call (201) 722-2928 for additional information.

CLASSIFIED ADVERTISEMENTS

CYTOLOGIST—M.D., recent Russian emigrant not yet licensed seeks position as cytology technician. Write Box 247, c/o JOURNAL MSNJ.

AVAILABLE—For Part-time service in Emergency Room of southern New Jersey hospital. Available June 1, 1981. Reply Box No. 243, c/o JOURNAL MSNJ.

INTERNIST—Board certified, with training and interest in hematology and oncology desires to associate in an established practice. Reply Box No. 246, c/o JOURNAL MSNJ.

PEDIATRICIAN—Pediatric board eligible, CMDNJ, intensive care experience. Desires part-time work at office, clinic or hospital. Available July. Telephone (201) 736-3048.

PHYSICIAN—GP, desires full-time office or clinic practice. Call in evenings (504) 272-9726 or write Box No. 242, c/o JOURNAL MSNJ.

RADIOLOGIST—Fully trained, is available for part-time or vacation coverage. Write Box No. 240, c/o JOURNAL MSNJ.

NEEDED—General or Internal Medicine Practice to Buy. Write Box No. 244, c/o JOURNAL MSNJ.

PRACTICE/OFFICE EQUIPMENT—FOR SALE—Burlington County internist leaving active practice. Ideal location. Opportunity for young family practitioner or internist. Available September 1. Write Box No. 245, c/o JOURNAL MSNJ.

OFFICE EQUIPMENT—FOR SALE—Retiring physician wishes to sell all his office equipment. Good condition. Reasonable price. Telephone (609) 482-1823, 1-3 P.M.

PRACTICE FOR SALE—Englewood Hospital Area, Bergen County. Internal Medicine and Family Practice. Practice is large enough to support 2 physicians. Principals only. Building and equipment negotiable. Write Box No. 118, Bergen County Medical Society, 170 Main St., Hackensack, N.J. 07601.

MEDICAL PRACTICE—FOR SALE—Pediatric Practice for six years in Newark. Has more than 10,000 charts. Good for Pediatrician and Family Practitioner. Price \$5,000 including all charts, furniture and equipment. Write Box No. 239, c/o JOURNAL MSNJ.

AVAILABLE—A 20-year established practice fully furnished and equipped in a suburban area available immediately. 364 Ridgedale Avenue, East Hanover, N.J. 07936. Call (201) 887-9167 or (201) 665-1000 ext. 233.

HOME/OFFICE—FOR SALE—Long established G.P. practice, office furnishings and spacious office-residence for sale due to recent death of physician. Outstanding Colonial-Revival structure, circa 1906, centrally located in professional-residential zone of small town (pop. 8,000) in a rural but developing area of Warren County in northwest New Jersey. Two hospitals nearby. Excellent location and opportunity for young family practitioner or internist. Write Box No. 48, Washington, N.J. 07882 or call (201) 689-1705.

HOME/OFFICE—FOR SALE—Office and eight room home in Elizabeth, N.J. Excellent location near schools, hospitals, public transportation. Suitable for single practice. Call (201) 353-5562.

COME PRACTICE in CAPE MAY COUNTY. Office space available now on Route 9 in Cape May Court House, near the hospital. Call (609) 465-5902.

OFFICE SPACE—Edison. New modern professional building. Will divide. Need all specialties. On site parking, near all major highways and hospitals. Call Dr. M. Bronstein (201) 826-5606.

OFFICE SPACE TO SHARE—Elizabeth. Large suite in modern professional building, centrally located, ample parking. Common waiting room and own three rooms. Call (201) 280-0250.

OFFICE SPACE—Englewood. 1200 feet. Can be divided. Ideal for psychiatrists and surgical specialties. Two blocks from Englewood Hospital. Ample parking. Call (201) 568-1441.

OFFICE SPACE—Livingston. For Rent in medical office conveniently located in Livingston. Call afternoons (201) 994-3200.

AVAILABLE—Robust General Practice. Eastern Union County, four hospitals nearby. Probable summer availability. Write Box No. 248, c/o JOURNAL MSNJ.

OFFICE SPACE—Available in an oversized medical office, newly decorated. Excellent location in Morris-Passiac County, near all major highways, 30 minutes to NYC. Phone (201) 337-1627 evenings.

INFORMATION FOR MEMBERS—RATES—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance.
WORD COUNT: Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JOURNAL MSNJ" as six words. **COPY DEADLINE**: Fifth of preceding month.

Heart disease and stroke
will cause half
of all deaths this year.

Put your money where
your Heart is.



American
Heart
Association

WE'RE FIGHTING FOR YOUR LIFE

SEE

CME—483

Investments—420, 432, 455

Personnel—487, 488

Real Estate—487, 488

Services—432, 442, 486, 487

Board Certified Internist

to serve as Medical Consultant—to review client medical records and advise medical disposition. One visit per week . . . salary—\$5945.76 per annum.

Address responses to: Mrs. Norma F. Krajczar, Executive Director Commission for the Blind and Visually Impaired, 1100 Raymond Boulevard, Newark, N.J. 07102

NEEMA EMERGENCY MEDICAL —a professional association—

Emergency Medicine Positions—available with emergency physician group in Pa., N.Y., N.J., Va., W. Va., Md. and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical

Suite 400

399 Market Street

Philadelphia, Pa. 19106

or phone

in Pa., (215) 925-3511

outside Pa., 800-523-0776

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$16,100 to \$18,400 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

PHYSICIANS

All specialties. Regularly scheduled hours, respectable salary, malpractice paid, free health/dental, 30 days paid vacation, many family benefits and more. Must qualify for commissioned officer in Navy Medical Corps.

Send C. V. to
Medical Programs Officer
128 N. Broad St.
Philadelphia, PA 19102
or call
(215) 597-9680
or 564-3820.

July 1981

Journal of
the Medical
Society of

New Jersey

Echocardiographic Criteria
Allen B. Weisse, M.D.

Cancer Mortality in
New Jersey
I. S. Thind, M.D., et al.

Conquest of Yellow Fever
*J. A. Bowers, M.D.
E. E. King*

Complete Table of
Contents on page 492



LIBRARY
U.C. SAN FRANCISCO

JUL 30 1981

Francisco
94143 S

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

***Check this list
against your
coverages***

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$7,500 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

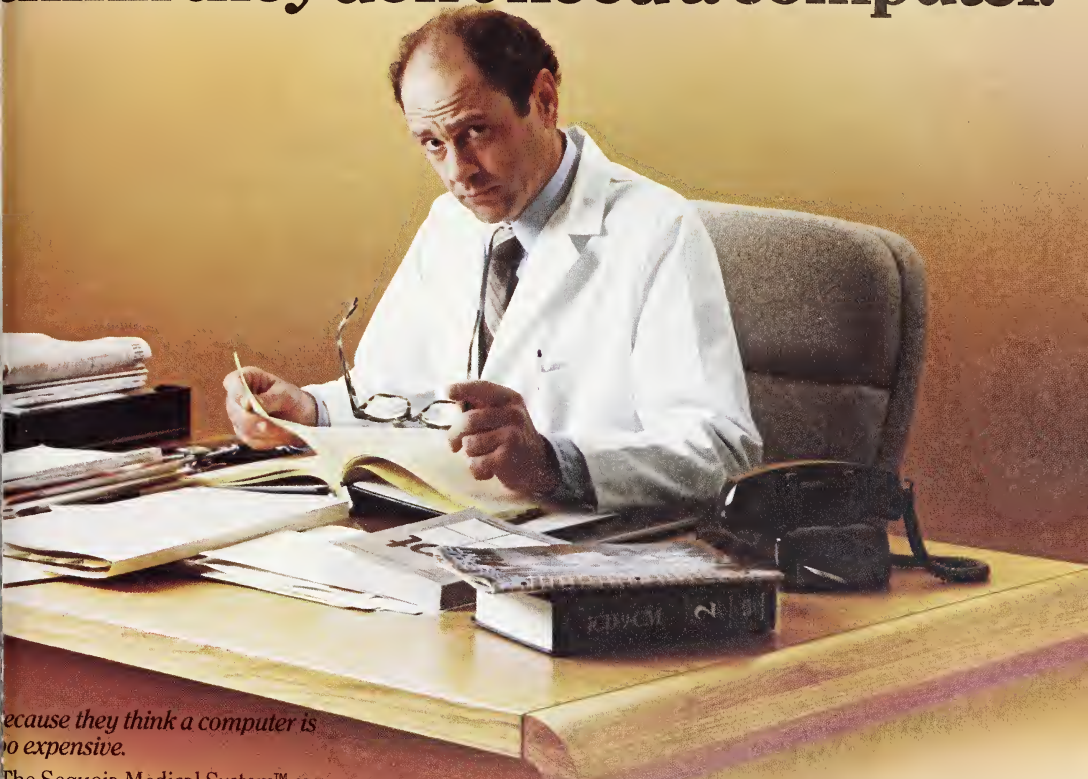
Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____

We're looking for doctors who think they don't need a computer.



because they think a computer is too expensive.

The Sequoia Medical System™ can pay for itself:

- Increased collections
- Decreased receivables
- Improved staff efficiency

because they think they already have firm control of their billing.

The Sequoia Medical System automatically processes billing paperwork:

- Patient statements
- Third party claims
- Collection letters

because they think they have easy access to vital practice data.

The Sequoia Medical System provides information immediately:

- Aged receivable reports
- Procedure and diagnosis analysis

- Daily production and revenue analysis
- On-line access to 4½ million medical journal articles in the National Library of Medicine
- And many other forms of essential data

Because they think a computer is administratively disruptive.

The Sequoia Medical System is designed to blend smoothly into solo and small group practices:

- Easy to use
- Pre-programmed, turn-key system

- Includes training, installation, local service and support.

Because they haven't seen a Sequoia Medical System.

Sequoia can provide more time for health care in your practice. While it's taking care of business... you're taking care of patients.

Start looking into the benefits of a computer today by calling Sequoia Group. Call toll free (800) 227-2360; in California (800) 772-2655... or write for our brochure.

SEQUOIA GROUP™

I N C O R P O R A T E D

1100 Larkspur Landing Circle, Larkspur, CA 94939

Hackettstown (201) 852-1612 or 852-5394

Michael Keys—Branch Manager

Atlanta, Birmingham, Boston, Buffalo, Charlotte, Chicago, Cleveland, Columbus, Dallas, Denver, Detroit, Hartford, Houston, Indianapolis, Irvine, Kansas City, Los Angeles, Memphis, Miami, Minneapolis, Nashville, New Orleans, New York City, Norfolk, Oklahoma City, Philadelphia, Phoenix, Pittsburgh, Portland, Salt Lake City, San Diego, San Francisco, Seattle, St. Louis, Tampa, Washington, D.C.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



Officers and Trustees

PRESIDENT	Armando F. Goracci, M.D. (Gloucester)	Woodbury
PRESIDENT-ELECT	Howard D. Slobodien, M.D. (Middlesex)	Perth Amboy
FIRST VICE-PRESIDENT	Alexander D. Kovacs, M.D. (Union)	Scotch Plains
SECOND VICE-PRESIDENT	Frank Y. Watson, M.D. (Essex)	Montclair
IMMEDIATE PAST-PRESIDENT	Augustus L. Baker, Jr., M.D. (Morris)	Dover
SECRETARY	Arthur Bernstein, M.D. (Essex)	East Orange
TREASURER	Rudolph C. Gering, M.D. (Mercer)	Pennington

Trustees

CHAIRMAN	
William Greifinger, M.D. (1984) (Essex)	Belleville
Meyer L. Abrams, M.D. (1982) (Burlington)	Cherry Hill
Frank Campo, M.D. (1984) (Mercer)	Trenton
Douglas M. Costabile, M.D. (1984) (Union)	Murray Hill
John J. Crosby, Jr., M.D. (1984) (Hudson)	Jersey City
Anthony P. DeSpirito, M.D. (1982) (Monmouth)	Neptune City
Ralph J. Fioretti, M.D. (1983) (Bergen)	Rochelle Park
Palma E. Formica, M.D. (1984) (Middlesex)	Old Bridge
Henry W. Fullerton, Jr., M.D. (1982) (Salem)	Carney's Point
Sherman Garrison, M.D. (1983) (Cumberland)	Bridgeton
John P. Kengeter, M.D. (1984) (Ocean)	Toms River
Myles C. Morrison, Jr., M.D. (1982) (Morris)	Morristown
Michael R. Ramundo, M.D. (1984) (Passaic)	Clifton
Bernard Robins, M.D., (1983) (Essex)	Springfield

Councillors

FIRST DISTRICT	(Essex, Morris, Union, and Warren Counties)	
Edward M. Coe, M.D. (1984)	.....	Cranford
SECOND DISTRICT	(Bergen, Hudson, Passaic, and Sussex Counties)	
Robert A. Weinstein, M.D. (1983)	.....	Newton
THIRD DISTRICT	(Hunterdon, Mercer, Middlesex, and Somerset Counties)	
Albert F. Moriconi, M.D. (1982)	.....	Trenton
FOURTH DISTRICT	(Burlington, Camden, Monmouth, and Ocean Counties)	
Frederick W. Durham, M.D. (1984)	.....	Haddonfield
FIFTH DISTRICT	(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)	
Ronald M. Fisher, M.D. (1983)	.....	Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982)	Hackensack
William J. D'Elia, M.D. (1981)	Spring Lake
Frederick W. Durham, M.D. (1982)	Haddonfield
Karl T. Franzoni, M.D. (1982)	Trenton
John S. Madara, M.D. (1982)	Salem
Henry J. Mineur, M.D. (1982)	Cranford
Myles C. Morrison (1981)	Morristown

July 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Julio C. del Castillo, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.
Harold Arlen, M.D.
Alfonse Cinotti, M.D.
Stuart D. Cook, M.D.
Robert Dodelson, M.D.
Wm. A. Dwyer, Jr., M.D.
Norman H. Ertel, M.D.
A. Olusegun Fayemi, M.D.
Arthur Goldfarb, M.D.
Robert A. Goldstone, M.D.
Murray Kahn, M.D.
Monroe S. Karetzky, M.D.
Avrum L. Katcher, M.D.
Sidney Ketyer, M.D.
Bernard J. Koven, M.D.
Joel D. Levinson, M.D.
Henry R. Liss, M.D.
Robert M. MacMillan, M.D.
Geobel A. Marin, M.D.
Murray Nussbaum, M.D.
Christopher M. Papa, M.D.
Victor Parsonnet, M.D.
Irwin Pollack, M.D.
Bernard A. Rineberg, M.D.
Edwin L. Rothfeld, M.D.
Benjamin F. Rush, Jr., M.D.
Morris H. Saffron, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Sheldon D. Solomon, M.D.
Lloyd N. Spindell, M.D.
A. Arthur Sugerman, M.D.
Robert B. Zufall, M.D.

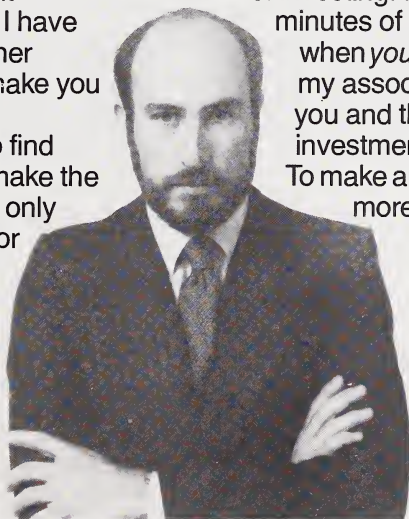
The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 926. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

MY SUNBELT CONDOMINIUMS CAN SAVE YOU TAXES AS SOON AS YOU BUY ONE, SHELTER YOUR INCOME WHILE YOU OWN IT, AND EARN YOU MOST ATTRACTIVE CAPITAL GAINS WHEN YOU SELL.

Now you can take advantage of what years of success in investment real estate have taught me—free.

It doesn't cost you a penny to learn about the best sunbelt condominium investments I have found for you and many other professionals. And it can make you a lot of money.

I travel the country to find condominiums I think will make the wisest investments. Select only the very best apartments for you to own. Write a report that covers all the questions good investors ask—the construction, the neighborhood, the view, and the appreciation potential. And, of course, the tax angles.



Before I recommend any condominium to you, I invest in at least one of its apartments for myself.

I'd like to tell you about my way of investing. It will take only a few minutes of your time, where and when *you* say, to show you what my associates and I can do for you and the health of your investment portfolio.

To make an appointment, or for more information, complete and mail the coupon below. Or, better still, call me right now at :

(201) 962-6300

Ken Gluckman
President
Skyline Associates, Inc.
72 Hickory Road
Ringwood, New Jersey 07456

FILL IN, MAIL NOW!

J-1

- ☐ Please call me to set up an appointment at no cost or obligation.
☐ Please send me more information.

Name _____ (Please print or type)
Address _____
City _____ State _____ Zip _____
Telephone () _____ () _____ office home



Skyline Associates, Inc.
72 Hickory Road, Ringwood, New Jersey 07456 • (201) 962-6300

Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

497 **PROFESSIONAL LIABILITY COMMENTARY**

EDITORIALS

- 501 The House Has Spoken
503 Coping With the Impending Doctor Glut
509 **JEMPAC REPORTORIAL**

ORIGINAL ARTICLES

- 513 Evaluation of Echocardiographic Criteria for Cardiac Tamponade
Allen B. Weisse, M.D., Newark
519 Preadmission Evaluation and Elective Cataract Surgery
B. A. Maltzman, M.D.; A. A. Cinotti, M.D.; J. P. Calderone, Jr., A.B., Jersey City
523 Acetaminophen Overdose
George W. Miller, Jr., M.D., Montclair
527 Trends in Cancer Mortality in New Jersey
I. S. Thind, M.D.; G. R. Najem, M.D.; I. Cohen, B.S.; R. Levy; D. B. Louria, M.D., Newark

CASE REPORTS

- 530 An Unusual Case of Hemophilus Influenzae Infection
Martha Stitelman, M.D.; Benjamin Josephson, M.D., Summit
532 Bile Peritonitis After Routine T-Tube Removal
N. Rosenberg, M.D.; S. F. Konigsberg, M.D.; N. M. Finkelstein, M.D., New Brunswick

SPECIAL ARTICLE

- 535 The Carrier Foundation
Robert S. Garber, M.D., Belle Mead

CLINICAL NOTE

- 538 TRS-80 (TM) and the Surgeon
Donald Rothman, M.D., Red Bank

MEDICAL HISTORY

- 539 The Conquest of Yellow Fever
John Z. Bowers, M.D.; Edith E. King, New York

542 **PEDIATRIC BRIEFS**

544 **THERAPEUTIC DRUG INFORMATION**

DOCTORS' NOTEBOOK

- 548 Medicaid Rule Proposals
548 CMDNJ Notes
549 ACP Fellows
549 Physicians Seeking Location in New Jersey
552 Report from the Foundation

552 **PERSONAL ITEMS**

553 **LETTERS TO THE JOURNAL**

556 **CME CALENDAR**

558 **OBITUARIES**

559 **BOOK REVIEW**

Cover

The two stamps used on our cover are from the private collection of Dr. Joseph H. Kler of New Brunswick, ophthalmologist, philatelist and medical historian, whose most recent contribution to *The Journal* was the article on Pasteur which appeared in the February 1981 issue.



You're Invited to Tour Our Facilities

The majority of physicians have never toured a modern rehabilitation hospital, and because of this we're extending an open invitation.

New Jersey Rehabilitation Hospital, located by Exit 145 of the Garden State Parkway, is a specialty hospital which treats catastrophic injuries to spinal cord and brain, stroke, quadriplegic, paraplegia, loss of limb, musculo-skeletal injuries, neck and low back injuries, and other mental and physical impairments, often resulting from automobile or work accidents.

To arrange for an escorted tour of our facilities, call Bucky Harris, at (201) 673-1860. We believe you'll be impressed with modern rehabilitation medicine.



New Jersey Rehabilitation Hospital

Owned and operated by Madencare Centers of America, Inc.

240 Central Avenue, East Orange, NJ 07018 • 201-673-1860

Bertrand J. Bensam, MD, Medical Director • Stanley Shepard, Administrator

Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities and the American Board for Certification in Orthotics and Prosthetics Inc.

Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white glossy

prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.


COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.



Acute pain is no laughing matter.

The first prescription for the first days of acute pain **Empirin® \bar{c} Codeine #3**

Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). 

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin \bar{c} Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin \bar{c} Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin \bar{c} Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg (Warning — may be habit-forming) 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

YOUR OFFICE CAN OPERATE UP TO 50 WAYS BETTER!

New Jersey Bell will show you how to reduce expenses and make your office hours more productive.

If routine procedures cause routine hassles in your office, New Jersey Bell can help. Bell System technology can make your office more efficient by decreasing communications snags, increasing productivity of your staff and reducing expenses. Consider the Horizon® system: it lets you create a customized communications system for your office, offering a range of over 50 features and services from which to choose. For instance . . .

- No phone will go unanswered when you have the Central Answering Point feature. So good relations with patients will be maintained, and emergencies will not be missed.

- Critical calls from patients, labs, or colleagues can bypass the receptionist and get through to you *immediately*, when you have the Direct Group Calling feature. This feature provides you with a personal line—not accessible to anyone else in your office.

- You'll be able to rearrange and restructure your communications system yourself, with the Customer Access Unit. This economical unit lets you make many routine changes yourself without a visit from New Jersey Bell. This will bring you maximum flexibility, and you'll save on service charges.

To find out about the 47 other ways a Horizon communications system can improve your office, contact New Jersey Bell. We'll provide an informative booklet on the Horizon system. And if you wish, you can discuss your specific needs with a Communications Specialist by calling us now, toll-free, at 800-242-0885. Or complete and mail the coupon below.

New Jersey Bell has ways to make your office more efficient. Find out what they are . . . and start saving time and money!

HORIZON SYSTEM INFORMATION REQUEST

(800) 242-0885

New Jersey Bell
Direct Marketing Center
Gateway II, 17th Floor
Newark, N.J. 07102

YES, I would like to increase efficiency and productivity in my office. Please send me your Information Kit on the Horizon® Business Communications System. And have one of your representatives contact me to discuss my specific needs. (please print.)

Name _____

Title _____

Address _____

City _____ State _____ Zip _____

Telephone # _____

Best time to call _____ HR-Q-7

The knowledge business



New Jersey Bell

Featuring: Epilepsy—Analysis of Medicolegal Problems Results of State Panel Hearings

EPILEPSY: ANALYSIS OF MEDICOLEGAL PROBLEMS

The medicolegal problems of epilepsy raise a number of complex issues, particularly in the area of professional liability, where physicians have a dual responsibility.¹

Physicians have a special responsibility not only to their patients, but also to third parties who are not patients. Liability may arise when a physician fails to warn an epileptic patient of his limitations in driving automobiles. Liability also may be incurred when a physician fails to report such an impaired patient to the appropriate state agency. When such suits have been instituted, they usually have been filed against physicians by parties injured by the epileptic motorist who has continued to drive and caused an accident due to his affliction.

According to a report in *Medical Trial Techniques Quarterly*, 1977, a New Jersey court allowed a suit against four physicians for failure to report. Each physician had failed to report the epileptic patient to the Department of Motor Vehicles under the reporting statute. The suit was brought by fellow passengers in a car pool who were injured when the driver suffered an epileptic seizure and crashed into a tree.

Our research has failed to substantiate any disposition of this case through the courts, leading to the hypothesis that an out-of-court settlement was made. It must be noted that this case arose in 1963 under a reporting statute which is no longer the law.

New Jersey's current statute, which became effective in 1970, substantially revised the earlier statute. The present law, R.S. 39:3-10.4 requires the following:

"Each physician treating any person 16 years of age or older for recurrent convulsive seizures or for recurrent periods of unconsciousness or for impairment or loss of motor coordination due to conditions such as, but not limited to, epilepsy in any of its forms, when such conditions persist or recur despite medical treatments, shall, within 24 hours after his determination of such fact, report the same to the Director of the Division of Motor Vehicles. The director, in consultation with the State Commissioner of Health, shall prescribe and furnish the forms on which such reports shall be made."

It may be helpful to analyze the statute as follows: Who must report? What conditions require reporting? When must the report be made?

The statute clearly requires each treating physician to report. It appears that a physician whose role is limited to that of a consulting physician may be under no duty to report. However, if the consultant also treats the patient, he may have a duty to report.

Each of the following conditions, whether or not due to epilepsy in any of its forms, is reportable: (1) recurrent convulsive seizures, (2) recurrent periods of unconsciousness, and (3) impairment or loss of motor coordination.

It is only when a treating physician determines the persistence or recurrence of the three enumerated conditions, despite medical treatment, that each treating physician must report his findings to the Director of the Division of Motor Vehicles. This report must be made within 24 hours of the physician's determination that the patient's condition is not responding to medication. The physician's determination should be based on the patient's history, physical examination and appropriate laboratory studies, as may be indicated.

The statute does not appear to require treating physicians to report cases of medically controlled epilepsy. The language of the statute suggests an attempt by the legislature to take into consideration the fact that convulsive disorders are not isolated to a single disease. The statute contemplates that disabling, reportable conditions may be caused by other diseases or syndromes in addition to epilepsy.

It is certainly possible that an emergency physician may incur a statutory responsibility to report a patient who is suffering from any of the three enumerated impairments. Obviously, each case will depend on the particular facts. In all cases where the treating physician determines that a patient's reportable condition is not medically controlled, the medical records of the patient should be documented appropriately. The record also should indicate that the patient has actual knowledge of the fact that he should not drive his automobile until further evaluation and treatment.

The patient should be referred promptly to his family physician or appropriate specialist for followup treatment. The emergency physician's report to the Department of Motor Vehicles must be made within 24 hours of his determination that the patient's condition has continued to recur or persist despite medical treatment.

Each treating physician who fails to report may risk liability. A California case reported in *American Jurisprudence, Proof of Facts*, 1980, is illustrative of the extent of the physician's potential liability for failure to report. Two physicians who failed to report an epileptic patient to health authorities settled their case for \$95,000 in damages resulting when the epileptic patient killed one person and injured three others in an auto accident.

A number of physicians have expressed concern that the patient will sue them for violating the confidentiality of the physician-patient relationship if the physician reports the patient's condition to state authorities. Some state lawmakers have anticipated this concern by explicitly providing immunity from civil liability for reporting such cases. New Jersey does not specifically provide such reporting immunity. However, common law immunity should protect the physi-

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

cian who reports in good faith under the statute. Courts throughout the nation have ruled that such reporting laws help to serve the public welfare by providing the state with the necessary information to deal intelligently with the social consequences of these clinical conditions.

This subject will be treated in greater detail in a future issue of the *Physician Legal Bulletin*.

RESULTS OF STATE PANEL HEARINGS

MIENJ, the physician-owned insurance company, recently reported on its experience with the State panel hearings established by the Courts under Rule 4:21.

This ruling mandates that all cases of alleged malpractice be heard by a panel consisting of a lawyer, a physician and a judge prior to trial. One of the prime purposes of this ruling is to assist in the elimination of nuisance suits and thus aid in the clearing of the Court calendar.

As of May 1981, fifty-two (52) files either have gone through a Rule 4:21 panel hearing or have been tried to conclusion. Of these 52 files

- 25 have been through a R:4:21 hearing but remain open. These panel results are:

- 19 Unanimously defensible

- 1 Defensible, split decision

- 3 Unanimously indefensible

- 1 Indefensible, split decision

- 1 No determination

- 23 have been through a R:4:21 hearing and are closed. The panel results are:

- 16 Unanimously defensible

- voluntary dismissal after the Panel—1

- voluntary dismissals within 45 days of trial—8

- judgment for the defense—7

- 2 Defensible, split decision

- judgment for the defense—1

- settlement—1

- 4 Unanimously indefensible

- 1 Credibility issue and Panel refused to render a decision judgment for the plaintiff—1

Peer Review found defensible. Issue was one of credibility as to what symptoms plaintiff displayed in the emergency room and to what insured said versus what plaintiff's wife said happened.

- 4 have gone through trial but never had a R:4:21 hearing. verdicts for the plaintiff—4

- Peer Review found defensible—1

Issue was informed consent; keloid scars following surgical resection of ulcer in neck in black woman.

- Peer Review found defensible—1

Medical issue over bowel burn from unipolar cautery. Defended on "spark jump" theory but plaintiff won on "failure to clear operative site and use care."

- Peer Review found defensible—1

Issue was how did plaintiff go blind in one eye after undergoing a sinusotomy. MIENJ's motion for a mistrial is pending.

- No Peer Review—1

Issue of law was application of the Nursing Home Bill of Rights (Medical Practice Act) about notice of transfer. Issue of credibility was that insured's records said he told plaintiff's wife the night before and plaintiff's wife denied this. Jury felt plaintiff's actions were not so bad as to constitute an emergent matter.

DID YOU KNOW

... In anticipation of a 71 percent rise in medical liability insurance premiums for physicians of New York, the Medical Society of New York is developing a statewide campaign to emphasize what might happen to health care delivery should this increase materialize. The new rates would raise premiums for the average New York physician to \$14,500, some orthopedic surgeons and neurosurgeons would pay \$49,500 and obstetricians/gynecologists would pay \$45,000.

... Ten days after New York's physician-owned company filed for a 71 percent increase the state's Joint Underwriters Association requested a 367.8 percent increase.

... St. Paul has initiated a sales campaign in competition with the doctor-owned State Volunteer Mutual Company of Tennessee which offers a premium rate half that of the doctor-owned company.

... Ohio and Michigan physician-owned insurance companies are offering physicians special rates for first and second years in practice. The first year physicians pay 35 percent of their usual rate and in the second year 70 percent of their usual rate.

... A New Jersey nurse was found guilty of "reckless manslaughter" in connection with a blood transfusion reaction that killed a heart patient. "Reckless manslaughter" carries a prison term of five to ten years.

... "If and when the rate increase is approved, it will be effective as of the approved date and not go back to the first of the year," stated Peter Sweetland, President of MIENJ, at the Spring Conference of Presidents and President-Elect. The physician-owned company has requested the Commissioner to grant a 9.7 percent rate increase.

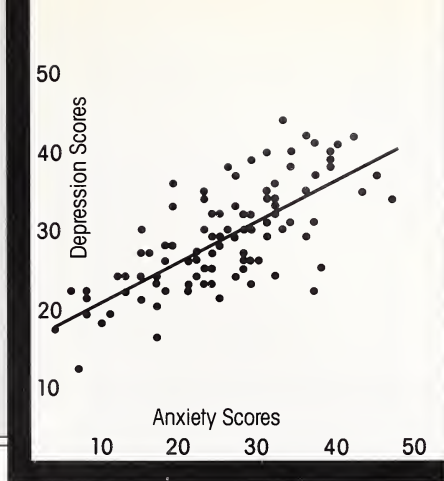
THE CHRONIC EMERGENCY ROOM PATIENT CAN SPELL MALPRACTICE

A patient entered the emergency room of a local hospital complaining of gastric pains, vomiting, neck and back pains. The patient was known to the staff as an individual who habitually visits the ER with complaints of a varied nature and usually under the influence of alcohol. A diagnosis of acute intestinal colic was made and the patient was treated with one cc of sterile water. Two days later the patient returned to the ER with the same complaint. The attending physician recommended the patient abstain from alcohol and consult his family physician. One day later the patient was admitted for appendicitis.

This case and two others having similar occurrences are presently in litigation. In each of the cases, the physician and involved staff formulated clinical evaluations of their previous perceptions of the emergency room patient. Physicians performing in an ER setting need to be scrupulous in the care and treatment rendered. A cavalier attitude in the treatment of the chronic ER patient becomes a prime ingredient of a malpractice claim.

Physicians are cautioned to be as attentive to the chronic ER patient as they are toward the conventional patient who enters the ER. The standard of care expected of a physician in conducting a history and physical examination, checking previous medical records and ordering and reviewing the proper tests should be equivalent to the care the physician would expect to receive for a member of his/her own family under similar circumstances.

The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scales in 100 nonpsychotic psychiatric patients. The coefficient of correlation is 0.7. As depression increased, so did the anxiety levels.¹



WHY MORE PHYSICIANS ARE CHOOSING LIMBITROL

It fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician¹ found a correlation of 0.7 in anxiety and depression scores; another² has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

References: 1. Claghorn J: *Psychosomatics* 11: 438-441, Sept-Oct 1970. 2. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. 3. Baldessarini RJ, Tarsy D: Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p. 999.

It is more appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression. These contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.^{2,3}

It avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

in moderate to severe depression and anxiety

Limbitrol®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

because it's specific for anxious depression in the nonpsychotic patient



LIMBITROL® TABLETS  **Tranquillizer—Antidepressant**
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use. Then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chloridazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chloridazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated—sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely. The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine sulfate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chloridazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chloridazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Packs of 50.

**We design offices
as if we had to
spend 8 hours a day
in them.**



We believe an office is more than just a place to work. Using the finest furniture, accessories and office systems our skilled design staff creates environments.

We handle all major lines of contract furniture and accessories, as well as floor and wall coverings, window draperies and blinds. Your choice is limited only by your imagination.

FARKAS, THE INTERIOR ENVIRONMENTALISTS.

FARKAS
BUSINESS INTERIORS INC.
SIXTEEN PINE STREET
MORRISTOWN, NEW JERSEY 07960
(201) 267-1055

MONDAY-FRIDAY 9 00 A.M. - 5 00 P.M. SATURDAY 10 00 A.M. - 2 00 P.M.

**NEW YORK
FERTILITY RESEARCH
FOUNDATION, INC.**

**For the Investigation of
Problems of Human Infertility**

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

**1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500**

The House Has Spoken

During the 215th Annual Meeting of the Medical Society of New Jersey, the 1981 House of Delegates met and made some decisions which probably reflect the conservative beat of the nation as a whole. The delegates debated and considered issue after issue with deep feelings and care, but it was clear that the mood of the House was somewhat different than it has been in recent years.

The matters of special importance which were adopted by resolution include the following:

PSRO

"RESOLVED, that the Medical Society of New Jersey strongly reaffirms the position of the AMA urging the repeal of the PSRO legislation."

This resolution was based on the opinion that the majority of members of MSNJ have objected to the concept of PSRO since its inception. It was felt that active participation in the PSRO process is not the only alternative to non-medical review of professional standards. The apparent strong pressure in the incumbent Congress of the United States to repeal the PSRO legislation was undoubtedly a stimulus to this resolution.

EQUAL RIGHTS FOR MEN AND WOMEN

"RESOLVED, that the Medical Society of New Jersey urge the AMA to affirm the concept of equal rights for men and women in all endeavors and activities."

Led by a female member of the Board of Trustees, who was also a delegate from Middlesex County, this resolution was based on the principles of fair play, e.g., "the AMA espouses the concept of equality for all individuals regardless of race, religion, age or sex," and AMA policy supports "equal opportunities for men and women in all phases of medical endeavors and activities." Furthermore, the Bylaws of the AMA have been changed to affirm civil rights and the AMA Principles of Medical Ethics which state that:

"A physician must recognize responsibility not only to patients, but also to society, to other health professions, and to self" and

"A physician shall recognize a responsibility to participate in activities contributing to an improved community."

FOUNDATION FOR HEALTH CARE EVALUATION

"RESOLVED, that the New Jersey Foundation for Health Care Evaluation no longer be funded by the Medical Society of New Jersey, and that any services necessary to the Society's membership be provided by the Board of Trustees or their appointees."

The funding of the Foundation has been an issue at meetings of the House each year since the Foundation became a reality. Known as "the operating arm of Professional Standards Review Organizations," the Foundation provided "information and advice toward the development of HMO and IPA plans" and, according to the sponsors of the resolution, "it has failed satisfactorily to convince a majority of the members that these organizations (HMOs and IPAs) function in their behalf" and, "this Foundation is contrary to present (federal) policy to reduce costs and regulations of health care delivery."

AFFIRMATION OF PRINCIPLES REGARDING UNNECESSARY REGULATION

"RESOLVED, that MSNJ, henceforth oppose any further governmental intrusion which, after due deliberation, is deemed not to be in the best interests of patients or their physicians," and

"RESOLVED, that MSNJ expend every effort to supply the necessary data to those legislators who are attempting to repeal or declare a moratorium regarding further extension of previously enacted laws and regulations to which the Society objects."

These resolutions were based on the opinion that "past policy decisions of the Medical Society of New Jersey have reflected a concession of the inevitability of governmental intrusion," and that "efforts to modify the impact of ill-conceived legislation through a posture of cooperation and collaboration merely have made physicians the scapegoats for the predictable failures." The "strong, general support for deregulation in all aspects of our lives" undoubtedly was a motivating factor in the adoption of these resolutions.

OPPOSITION TO FURTHER INTRUSION BY THE FEDERAL GOVERNMENT INTO THE PROVISION OF HEALTH INSURANCE

"RESOLVED, that the Medical Society of New Jersey oppose any additional forms of federally controlled health insurance."

The concept that federal catastrophic health insurance, whether implemented by the federal government or through private insurers, represents "a further step toward national health insurance" was emphasized. Furthermore, "the current mood of the people and statements of the Reagan administration advocate less regulation in all aspects of our lives." It was the latter principle that seemed to move this resolution forward.

PROGRAM EXTOLLING BENEFITS OF THE PRIVATE PRACTICE OF MEDICINE

"RESOLVED, that the Council on Public Relations develop and implement a program extolling the benefits of the private practice of medicine to the people of New Jersey."

This, like other resolutions, emphasizes the dangers of government intrusion into the private practice of medicine. The feeling was that the public was not being informed "of the values and benefits of the private practice of medicine."

MODIFICATION OF THE MEDICAID PROGRAM

"RESOLVED, that the Medical Society of New Jersey recommend to the Governor and the State Legislature that the State Medicaid program be modified so as to provide a usual and customary fee to physicians or services rendered."

The principles behind this resolution were:

1. Medicaid was designed to provide equitable health care for the indigent population and has failed to do so.
2. Fees for medical services provided to Medicaid recipients were originally inadequate.
3. Medicaid has failed to keep pace with the inflationary spiral and in most cases the fees paid no longer cover the physical overhead of such services, let alone a reasonable fee for physicians' services.
4. Medicaid has demeaned both physicians and health care recipients.
5. Physicians wish to recreate a personal doctor-patient relationship based on the mutual responsibility of the patient for his own health care and the doctor for the provision of that care.
6. The physicians of New Jersey are willing to render health care for the patients of New Jersey regardless of the patient's ability to pay.

DISCONTINUATION OF FUNDING FOR HEALTH MAINTENANCE ORGANIZATIONS

"RESOLVED, that the Medical Society of New Jersey urge the House of Delegates of the American Medical Association to recommend to the enabling committees of Congress and to the Health Care Finance Administration (HCFA) that any further grants or loans to health maintenance organizations be abolished."

The AMA position on this subject in December 1980 was reaffirmed by the Council on Medical Service as follows:

"Approval of the concept of neutral public policy and fair market competition among all systems of health care delivery continue to be AMA policy, with the potential growth of HMOs being determined not by federal subsidy, preferential federal regulations, and federal advertising promotion, but by the number of people who prefer this mode of delivery."

The total amount of grants and loans for HMOs/IPAs in

New Jersey as of November 14, 1980 was \$23,610,110. The sponsors of this resolution were encouraged by reports that the Reagan Administration plans to ask that the federal grant and loan subsidy program for health maintenance organizations be eradicated.

HEALTH SYSTEMS AGENCIES (HSAs)

"RESOLVED, that the Medical Society of New Jersey memorialize the AMA to continue to seek repeal of P.L. 93-641 (National Health Planning and Resources Development Act)" and

"RESOLVED, that the Medical Society of New Jersey develop a means to promote the involvement of member physicians in health planning."

These resolutions came from the Board of Trustees itself, which agrees with the concept of health planning but has "the perception that the HSAs are not cost effective and tend to be arbitrary in granting or denying expansion of health services. It is also perceived that increased participation of physicians in the planning process at the county organizations and local hospitals will provide a substantial opportunity for improvement of health services in New Jersey."

OPPOSITION TO DIAGNOSIS RELATED GROUPS

"RESOLVED, that the Medical Society of New Jersey reaffirm its opposition to the concept of diagnosis related groups," and

"RESOLVED, that the Medical Society of New Jersey take the leadership role in coordinating opposition to DRGs, and in supplying appropriate data to the Legislature."

The sponsors of the resolution felt enabling legislation was enacted with minimal appreciation of the problems entailed in its implementation. It was emphasized that the DRG approach to hospital reimbursement initially received conditional approval from the Medical Society of New Jersey upon assurance that it was a limited experimental program—an assurance which was rescinded by the New Jersey State Department of Health without mutual consultation.

The House of Delegates debated issues of importance to every physician in New Jersey. Each doctor should read the details of the proceedings of the House and he must realize that actions of the Board of Trustees and of the delegates to the House from the county components on such weighty and important topics as DRG, HSA, PSRO, HMO and other health concepts in the alphabet soup of acronyms and abbreviations which represent the medical-governmental-political action scene of today, are in the best interest of patient care and the provision of high-quality health services first and foremost. Freedom of the medical profession and the individual practitioner is crucial, but patients always receive primary consideration.

A.K.

Coping with the Impending Doctor Glut*

There is now general agreement that a doctor surplus is virtually inevitable during the next decade.¹⁻⁴ Between 1980 and 1990 the number of physicians in this country will increase by 150,000, exclusive of foreign-born and trained physicians.^{2,3} We will have about 600,000 physicians, a ten-year growth of about 33 percent, a far greater increase than in the population at large. According to a recent report of the Graduate Medical Education National Advisory Committee (GMENAC) this will give a projected physician excess of 70,000 by 1990 and 145,000 by the year 2000.⁴ The projected surplus in the year 2020 will be staggering.

The question no longer is whether a doctor glut will occur; it is what we should do to reduce its impact. Unfortunately at present no adequate actions are being taken. Indeed the initial reactions to the reports by groups that may be affected most appear to be following the territorial imperative—protecting one's turf by a combination of denial and planned inaction.

At present most people believe that the physician supply is like any other market place item—the more doctors available, the greater the competition and the less the cost. They regard any attempt to control physician supply as avarice on the part of the medical profession. Their assumptions are of course simply not true. The evidence is clear that the more doctors, the greater the costs; similarly the more surgeons, the more operations.⁵⁻⁶

There are several actions that can be taken to ameliorate the doctor surplus problem. There almost certainly must be a reduction of several thousand students in each of the four years in American medical schools and no increase in the number of osteopathic students.^{1,4} This is needed if our communities are not to be flooded with physicians. Such a reduction would help restore a balance between students and faculty. In the last decade medical school student numbers have increased markedly but this has not been accompanied by a commensurate increase in faculty size and I believe this has hurt medical school teaching programs. A restoration of some semblance of balance is highly desirable.

Additionally, we must do something about a growing and uncontrolled medical student population—the Americans in medical schools overseas. Their numbers grow far faster than those in American medical schools. At present there are an estimated 12 to 18 thousand Americans studying abroad; not many years ago there were only six to eight thousand. According to the Educational Commission for Foreign Medical Graduates, in a one-year period—1979-1980—close to 3,000 Americans registered for the first time for the ECFMG test. Since many foreign schools are new and their students would not have been ready for ECFMG testing in the 1979-1980 year, this suggests the 12,000 figure is low.

It does no good to control the size of American medical school classes if at the same time we have an unregulated and rapidly growing pool of American students overseas. We must register these students and pass regulations that only a certain number, perhaps 3,000, can be licensed in any given year. If we do not do this, we will have a totally uncontrollable doctor glut.

One of the major recommendations of the GMENAC states: "the number of graduates of foreign medical schools entering the United States yearly, estimated to be 4,100 by 1983, should be severely restricted." That recommendation

covers both American and foreign-born students. I believe this is a misguided recommendation. It will not solve the issue of increased numbers of Americans training abroad since in supportive recommendations the Committee urges that such students be required to pass Part I and II of the National Board of Medical Examiners examination. Presently such graduates must pass the Federal Licensure Examination which has become comparable to the National Boards. Consequently the recommendation might make it somewhat more difficult for Americans trained overseas to return by increasing the severity of the examination but the implementation of the recommendation will not control numbers; only registration and licensure restriction will prevent a massive influx of Americans trained overseas. If this is not done the recommendation for a minimum ten percent cut in medical school class size will be worthless because any reduction in American medical school output will be counterbalanced by an excess of Americans trained abroad.

The part of the GMENAC recommendation that applies to foreign-born and trained physicians is to me both immoral and counter-productive. Since the health problems of the developing world are enormous and we possess a superb system of our own, it would be deplorable if we refuse to help train foreign physicians.

We must provide foreign-born and trained physicians with adequate amounts of graduate training and then insist they return to their own countries. Many feel that most of these physicians will never return and will do virtually anything to be allowed to practice here. Our laws and regulations must be so structured that even if they remain in the United States they cannot obtain a license—unless their country and ours agree such licensure is in the interests of both countries or alternatively they return to their own countries and enter via the usual immigration procedures.

Another reason for accepting foreign physicians for training is that there is a gap between the number of Americans available for residencies and the number of positions available. Several thousand positions each year cannot be filled by Americans. We could fill them by increasing medical school enrollments or by encouraging expansion of the number of Americans studying overseas. That is just what we should not do. In hospitals the doctor:patient ratio is very high; it is much less in the community. If we fill the gap with Americans, when they go into community practice, the communities will be flooded and the doctor glut will be even worse. We need to fill the gap with well-trained foreign physicians who then return to their own countries.

If we reduce our medical school output, there will be a greater gap between available first-year residencies and the American physician supply (and this will be true even if several thousand Americans trained abroad are available). One simplistic solution is to cut the number of residencies offered but that too is an undesirable tactic. Based on data provided by the American Hospital Association and the American Medical Association it would appear that as of 1977 there were about 400,000 acute care beds in hospitals with accredited residency programs and 14,000,000 ad-

*The author, Donald B. Louria, M.D., is Chairman of the Department of Preventive Medicine and Community Health, New Jersey Medical School, CMDNJ, and may be addressed there (100 Bergen St., Newark, N.J. 07103).

missions to these hospitals. This contrasts with about 600,000 beds and 20,000,000 admissions to hospitals without accredited residency programs. Reducing the number of accredited residencies will be deleterious to physicians and patients alike since there is general agreement that residency programs benefit both physician education and patient care. Instead of reducing the number of residencies, we should be trying to persuade hospitals to have full-time directors of medical education and more full-time or geographic full-time physicians so that they can qualify for teaching programs.

We should make the tests for foreign-born, foreign-trained physicians fair and we should develop a matching plan for foreign-born medical students who pass the examination. There should be a quota system so that every hospital with an accredited residency program would have to take a certain number of foreign-trained physicians in a fixed ratio of Americans:foreigners. No longer would the less fortunate hospitals get the foreigners while the better-known hospitals accept only Americans.

The doctor glut is fast approaching. By 1990 the problem of excess physicians will be an established fact and then it will

be too late for all but Draconian measures such as massive reductions in American medical school class size and prescription of overseas medical school training for Americans.

We must move promptly to cope with the coming doctor surfeit; if we do not, the situation will become progressively worse and within the next decade everyone—doctors and the public—will suffer.

Donald B. Louria, M.D.

References

- ¹Louria DB: Coping with the approaching doctor glut. *N Engl J Med* 300:1047-1049, 1978.
- ²On the status of health professions personnel in the United States. DHEW Publication No. (HRA) 78-93, August 1978.
- ³Forecasts of physician supply and requirements. Congress of the United States, Office of Technology Assessment, Washington, D.C., April, 1980 (U.S. Gov't Printing Office 052-003-00746).
- ⁴Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services, Sept. 30, 1980.
- ⁵Califano JA Jr: The government medical education partnership. *J Med Ed* 54:19-24, 1979.
- ⁶Wennberg J, Gittelsohn A: Small area variations in health care delivery. *Science* 182:1102-1108, 1973.



***You know
what you want
in Step-1
antihypertensive
therapy...***

For your hypertensive patients,

Long-acting

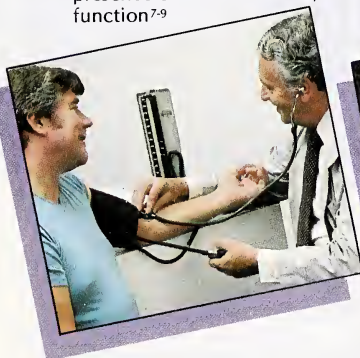
Zaroxolyn[®] gives **(metolazone) Pennwalt**

Efficacy

Start with Zaroxolyn because of its unsurpassed effectiveness in Step-1 therapy.^{1,4}

Stay with Zaroxolyn because it maintains effectiveness in long-term therapy^{1,5,6}... and minimizes the need for Step-2 agents.

- ☐ Zaroxolyn's effectiveness is maintained even in the presence of reduced kidney function⁷⁻⁹



Compliance

Stay with Zaroxolyn because it maintains 24-hour blood pressure control with simple once-daily dosage, and only 4% discontinue therapy due to side effects!



Safety

Stay with Zaroxolyn because clinically significant side effects are rare!

- ☐ Low incidence of changes in serum K⁺, glucose metabolism, or uric acid levels



you what you want

Compatibility

Add to Zaroxolyn easily if Step-2 agents become necessary.

- ☐ Permits lower doses of Step-2 agents to minimize side effects
- ☐ Allows flexible dosage titration, in contrast to fixed-dose combinations

Economy¹⁰

- ☐ Less expensive than most other diuretics
- ☐ More economical than hydrochlorothiazide in fixed-dose combination with triamterene or reserpine/hydralazine
- ☐ Costs less than beta-blockers
- ☐ Less expensive than methyldopa, clonidine, or prazosin



Start with...stay with...and add to...

Long-acting

Zaroxolyn[®]

(metolazone)

Gives you what you want in
Step-1 antihypertensive therapy

Please see following page
for prescribing information.



Long-acting

Zaroxolyn®
(metolazone) Pennwalt

2½ mg, 5 mg, 10 mg tablets

**Gives you what
you want in
Step-1 antihypertensive
therapy**

- ☐ Unsurpassed Step-1 efficacy in mild to moderate hypertension
- ☐ True once-daily dosage for excellent patient compliance
- ☐ Positive side effect profile
- ☐ Strong foundation for stepped-care therapy
- ☐ Long-term economy

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium

depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy.

How Supplied: Tablets, 2½, 5 and 10 mg.

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JB, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin-angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York, Stratton, 1976, pp 221-245. 3. Pilewski RM, Schnell ET, Misage JR, et al: technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotius S, Mroczek WJ, Davidoff M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Puscheck JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezzai E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book* 1981, and manufacturers' suggested prices.

Pennwalt
DIVISION
ROCHESTER, NEW YORK 14623

Medical Politics and the Reagan Campaign†

At 8:00 a.m. one hot August morning last summer my telephone rang. The caller was Dr. James Maislin who identified himself as the Physician Coordinator for Delaware, Pennsylvania and New Jersey in the "Physicians for the Reagan-Bush National Campaign." He had heard that I was a Reagan supporter and asked if I would be willing to be Chairman of "Physicians for Reagan-Bush" in the State of New Jersey. I thought about the other commitments I had made but decided it was an opportunity I should not pass up. Thus there opened a new chapter for my memoirs which perhaps was the most unique experience of my many years in the practice of medicine. Total commitment and dedication are vital to the success of any effort on behalf of a candidate.

Philosophically I was committed to Ronald Reagan from the beginning and strongly believed in the viability of his candidacy. I had listened to Mr. Reagan speak in 1976 when he visited New Jersey and had followed the current primaries with considerable interest. I believed someone with a conservative philosophy such as his was needed to reshape and redirect the destiny of our country. I believed that oppressive taxes and regulations were stifling initiative and growth and I believed that our position of strength in the world had been steadily eroding under the Carter administration. In short, I believed in and was willing to work for Mr. Reagan's candidacy.

Two events in the past had stamped me as "the Reagan man" in the state. The first was a large and successful party for Mr. Reagan on May 18, 1980, at my home. I was fortunate to have Ronald Reagan's brother-in-law, Dr. Richard Davis of the University of Pennsylvania, as a special guest along with Congressman Jim Courter, Republican from the 13th District. The other event was during a JEMPAC wine and cheese reception for presidential candidates—Mr. Reagan's surrogate speaker did not arrive and I took the podium to speak on behalf of Mr. Reagan's platform.

I was invited to attend a one-day conference at the Reagan-Bush National Headquarters on September 5, 1980, in Arlington, Virginia. I flew to Washington and attended the all-day conference which I found most fascinating. I had an opportunity to meet Dr. David Olch who was Chairman of "National Physicians for Reagan-Bush" and also to meet Dr. William Walsh who was to be Mr. Reagan's spokesman on medical issues. Also present were Dr. Richard Palmer, former AMA President and Mrs. Hoyt Gardner representing her husband, another former AMA President. There were physicians representing medical specialties from everywhere in the country, most of whom never had been involved in a

major effort like this.

We were briefed in a large conference room, one wall of which was a map of the United States studded with flags and pins to mark the week's progress of the Reagan-Bush entourage. Bill Timmons, of the White House Staff gave us a brief overview on political strategy. Prior to this meeting, I was of the opinion that some sort of core policy had been thought out by the Reagan forces and that we would now hear the Reagan-Bush Platform. As the meeting progressed it became obvious that there were no firm policies on any of the issues. As a matter of fact, there was no comprehensive description of the Reagan-Bush Program. Dr. Walsh gave the strong impression that input from practicing physicians would be welcomed. In subsequent correspondence, Dr. David Olch, of Los Angeles wrote to indicate that the opinions of the "Physicians for the Reagan Group" and others in medical practice would be sought actively in the future. Whether this ever will come to pass is any cynic's guess.

Principles of philosophy concerning Mr. Reagan's general espousal of private enterprise, less regulation, and a long-time aversion to socialized medicine were the topics of the day. I asked a number of specific questions, not only about issues, but about mechanics, such as, what could physicians do at the local level and what the campaign laws allowed in terms of deduction. The questions were parried with a lawyer's vagueness and again there were no solid facts. I flew home realizing that I had traveled to the mountain and found it wanting.

I decided that the least complex and most efficacious way to try to organize would be along county lines. I was able to obtain the names of physicians in each county who had been active in the political process in the Medical Society and/or JEMPAC and immediately began calling them. What the public says about trying to locate doctors is sometimes true. I had monumentally difficult times in locating some people. More often than not, however, there was a friendly voice on the other end of the phone, a brother-in-philosophy, who agreed to serve as a Chairman.

Doctor Sam Southard, an Atlantic County pediatrician, is an excellent example of one who aided me in my efforts. He was my right hand and a great stalwart worker throughout the campaign. He was recovering from total hip surgery and had time on his hands although he was somewhat incapacitated. He became a whirlwind on the telephone and did a tremendous job in helping organize most of the southern half of the State. However, there were refusals. I had a particular problem in getting someone to chair Mid-

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

†A personal experience of William E. Ryan, M.D., Pennington internist who is Treasurer of JEMPAC.

dlesex County and in Hudson County, despite leads furnished by Dr. Daniel O'Regan and Dr. Charles Cuniff, I could not find a physician to serve as chairman. There were other difficulties—two county chairmen were on prolonged vacations and one chairman had an accident and was sidelined most of the time.

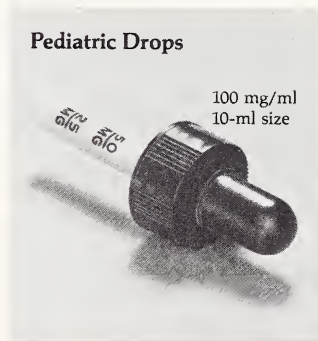
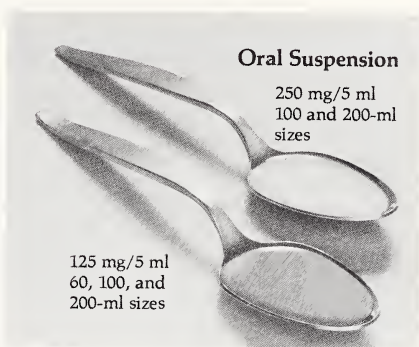
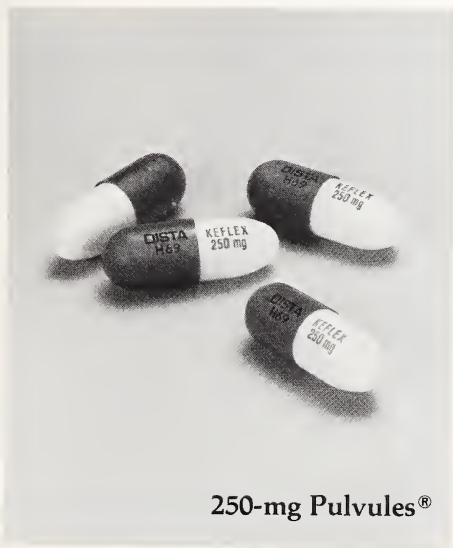
Through liaison with the Washington Office, I obtained an abundance of information—bumper stickers and other items were sent to county chairmen. These were passed along and phone calls aided in a followup. It appeared that most people were making a serious attempt to be helpful and support the cause. Physicians such as Ed Schauer, Gus Baker, Al Alessi, Frank Romano, and Alan Braun appeared to be pulling out all the stops. Most of our efforts were in the form of personal contact, literature distribution, bumper stickers and fund raising in the form of checks to the Reagan-Bush *Compliance Fund*.

Toward the end of the campaign I became quite apprehensive. I understood from a physician colleague in Princeton that Dr. George Gallup had made a prediction that New Jersey was swinging to President Carter. I decided the weekend before the election that I had better canvas as

many physicians and neighbors as I could. So for a couple of days I got out there early and rang doorbells distributing Reagan-Bush literature and talking to neighbors and friends about the election. To those people who were not at home, I left one of my prescription pads with a notation that this "house call" was made for the candidacy of Reagan-Bush. I can tell you that it takes quite a bit of stamina to cover a neighborhood. The job always looks smaller than it is. I learned a few basic principles of door-to-door campaigning such as staying on the sidewalks and avoiding lawns, especially, in homes with dogs! On election night, I went to the local Republican Headquarters and was asked to work on the election poll. During the evening I thought that those who had turned out to vote seemed like a representative bunch and that the tally probably would reflect this. As the evening drew to a close, we began to tally the votes and I was stunned to see Reagan doing so well.

I drove a party worker to the Court House to certify the votes and on the way listened to the car radio. When it was announced that President Carter had requested air time to concede, I knew the efforts of the physicians in the State along with a great many others had been successful.

easy to take



Keflex® cephalexin

Additional information available
to the profession on request.



Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

At 4:25 PM mild mannered Sheryl DePaul made a harried doctor smile.

Sheryl is part of our special Blue Shield professional relations staff. Sheryl and her colleagues specialize in answering physicians' questions. You can depend on our professional relations staff for quick answers to your questions regarding claims, billing information, and contract interpretation.

In addition, professional relations staff members handle the enrollment of new participating physicians, and the training of medical assistants.

So, next time you run into a Blue Shield related problem, call on us for the answer.



*"It's our job to
make things simple."*



Blue Shield of New Jersey

An Evaluation of Echocardiographic Criteria for Cardiac Tamponade*

ALLEN B. WEISSE, M.D., Newark

Recently suggested M-mode echocardiographic criteria for cardiac tamponade were evaluated in six instances of cardiac tamponade in order to determine their relative reliability. Although no single criterion for cardiac tamponade was universally applicable, in general, tamponade was unlikely to be present without anterior as well as posterior pericardial effusion and without some evidence of right ventricular compression. Clinical findings such as central venous pressure elevation and pulsus paradoxus were invariably of assistance in making the correct diagnosis when echocardiographic criteria were not fully met.

Since the earliest ultrasound studies demonstrating their usefulness in diagnosing pericardial effusion,^{1,2} M-mode echocardiography has become recognized as the most convenient and sensitive method for detecting the presence of pericardial fluid. Inasmuch as the progression of lax effusions to tense ones represents a life-threatening complication in such patients, more recent investigative efforts have been focused on determining echocardiographically the presence of tamponade complicating pericardial effusion³⁻⁶ although the ultimate reliability of such criteria for tamponade awaits further confirmation. Two-dimensional echocardiography is proving helpful in revealing pericardial fluid distribution and in differentiating pericardial from pleural effusions but, thus far, has not demonstrated any additional usefulness over M-mode echocardiography in the diagnosis of cardiac tamponade.^{7,8} We have therefore reviewed our recent experience with M-mode echocardiography in patients with cardiac tamponade to evaluate the usefulness of various criteria that have been suggested for making this diagnosis.

METHODS

From College Hospital we obtained the records of five patients carefully evaluated between 1976 and 1980 in whom we had made the diagnosis of six episodes of cardiac tamponade and in whom technically adequate echocardiograms pre and postpericardiocentesis were available for

analysis. All had elevations of central venous pressure by catheter and were examined for the presence of pulsus paradoxus (a decrease of over 10 mmHg in systolic cuff pressure with quiet inspiration). None was extremely obese or had chronic obstructive pulmonary disease where pulsus paradoxus also may be present.⁹ Cardiac tamponade was accepted as the diagnosis when any of the following occurred after pericardiocentesis: a rise in systolic blood pressure of 15 mmHg or more; disappearance of pulsus paradoxus; a fall of 5 cm H₂O or more of the initially elevated venous pressure.

Echocardiograms were recorded using either an Irex System II or Hoffrel Model 101C echocardiograph interfaced with an Electronics for Medicine DR-12 strip chart recorder at paper speeds of 25 or 50 mm per second. A 2.25 MHz transducer focused at 7.5 cm was utilized in all patients. All tracings were performed with the patient at 45° to 60° from the horizontal and the transducer in a left intercostal space parasternally. Transducer angles or interspace were adjusted as required postpericardiocentesis in order to obtain similar views through the heart pre and postremoval of large amounts of fluid which may have resulted in shifts of cardiac

*This investigation, from the Department of Medicine, Division of Cardiovascular Diseases, College of Medicine and Dentistry of New Jersey—New Jersey Medical School—College Hospital, Newark, was supported in part from research grants from the Union County Chapter and New Jersey Affiliate of the American Heart Association. Dr. Weisse is professor of medicine at the College. He may be addressed there—100 Bergen St.—MSBI-576, Newark, NJ 07103.

Case-Diagnosis	Status	Clinical Signs			Effusion Ant/ Post (mm)	Echocardiography								RVIDd (mm)	LVIDd (mm)
		Arterial Blood Pressure (mm Hg)	Pulsus Paradoxus (mm Hg)	Central Venous Pressure (cmH ₂ O)		Estimated Size of Effusion (ml)	Mitral Valve E-F Slope (mm/sec)		Mitral Valve D-E Amplitude (mm)		RVIDd (mm)		LVIDd (mm)		
1. CR 43 y/o M Bronchogenic Carcinoma	Before	130-110/80	20	19.0	var*	var*	Exp ?*	Insp ?*	Exp ?*	Insp ?*	Exp var*	Insp var*	Exp ?*	Insp ?*	
	After (600 ml)	130/80	0	6.5	0/10	490	-	-	-	-	-	-	-	-	
2. GS y/o M Chronic Renal Failure	Before	90/60	0	29.0	15/3	1200	45	28	12	10	13	18	?	?	
	After (1040 ml)	130/86	0	15.0	0/3	145	28	23	18	16	22	28	55	55	
3. JS 24 y/o M Purulent Pericarditis	Before	133-126/86	7	24.0	8/13	652	83-99	83-99	20	20	20	20	?	?	
	After (190 ml)	140-136/90	4	8.0	0/13	430	68	68	20	20	20	20	?	?	
4. RW 49 y/o M Chronic Renal Failure	Before	150-135/98	14	31.0	10/9	730	40+	62	13+	22	0	12	57	48	
	After (920 ml)	180-170/110	10	18.0	0/0	100	var	var	20	10	10	22	55	?	
	8/18/78	154-150/100	4	28.0	0/12	540	?	?	15	16	9	18	53	47	
	Post-Op	140-136/90	4	9.0	0/0	-	97	65	18	17	12	26	55	50	
5. FL 57 y/o M Chronic Renal Failure	Before	160-130/84	30	29.9	13/4	555	var	var	15	15	15	15	-	-	
	After (610 ml)	190/84	0	10.8	0/2	255	var	var	18	18	31	31	62	62	

Abbreviations: Ant/Post = anterior/posterior depth of effusion in mm; RVIDd & LVIDd = right and left ventricular end-diastolic dimensions; Insp = inspiration
Exp = expiration; var = too variable to measure accurately; ? = unable to measure.

*Distortion from excessive swinging of heart with electrical alternans and inability to record clear echos obviated reliable measurements

+ Probably artifact (see text)

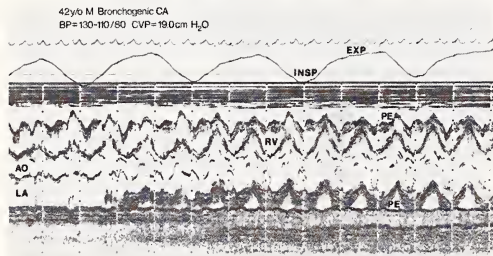


Figure 1a—Initial echocardiogram of case 1 shows pericardial effusion (PE) primarily anterior to the heart in this sweep from the level of the aorta to the left ventricle. Note that for every apparent mechanical cycle of the heart there are two QRS complexes. Electrical alternans (not well seen here) was also present. Because of the marked mechanical alternans, it was difficult to evaluate significance of dimensional changes in right ventricle (RV), mitral valve anatomy and right ventricular epicardial echoes (Ao=aorta, LA=left atrium, INSP=inspiration, EXP=expiration.) Time marker set at one second and depth marked at one cm intervals in this and other figures.

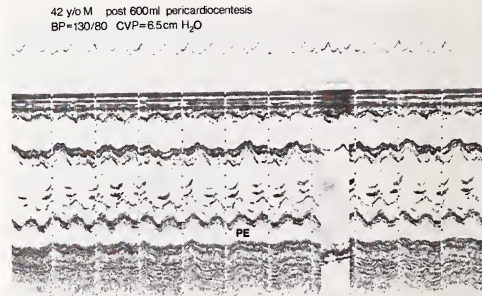


Figure 1b—Case 1 after pericardiocentesis was performed. The right ventricle is now flush against the anterior chest wall and all remaining fluid now appears posteriorly. Mechanical alternans and associated echocardiographic appearances have disappeared. No RV compression at any time is apparent.

anatomical position within the pericardial sac.

Before and after cardiac tamponade inspiratory and expiratory measurements were made when possible of mitral E-F slope, mitral D-E amplitude, and ventricular dimensions in systole and diastole. Specifically sought as possible signs of cardiac tamponade were:

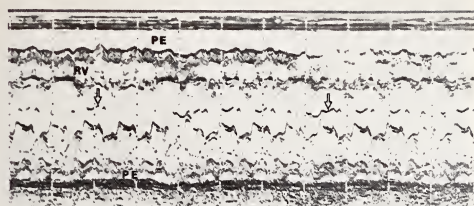
1. Inspiratory decreases in mitral valve E-F slope and D-E amplitude only during tamponade.^{3,4}
2. Inspiratory increases in right ventricular dimension during tamponade with reciprocal left ventricular changes.^{3,4}
3. Systolic notching on the right ventricular epicardial echo 0.03 to 0.05 seconds after the QRS.⁵
4. Right ventricular minor axis narrowing or compression

at end diastole and end expiration.⁶

5. Prominence of anterior effusion relative to posteriorly located effusion.

An estimation of the size of the pericardial effusion was made pre and postpericardiocentesis by the method of Horowitz and coworkers.¹⁰ Relative amounts of fluid anteriorly and posteriorly were expressed at end diastole in millimeters as a ratio.

Electrocardiograms and pneumographs for timing of events were simultaneously recorded with echo tracings. Pneumographs were obtained during tamponade in the first three patients. In the fourth (case 2), the inspiratory phase of respiration was assumed when the right ventricular end-diastolic dimension was maximal with concurrent minimal measurement for mitral valve E-F slope and D-E amplitude. In the fifth, there was obviously no difference in ventricular



Post-1040 ml Pericardiocentesis

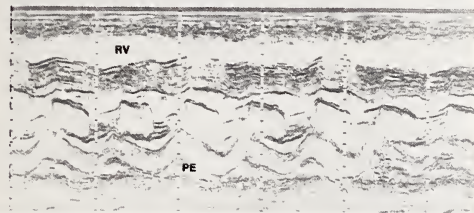


Figure 2a—Case 2, initial echocardiogram at the level of the mitral valve (paper speed 25 mm/sec). A PE, predominantly anterior, is shown. With inspiration the mitral valve E-F slope fell 17 mm/sec (from 45 to 28 mm/second) and the RV cavity, although containing some non-specific echoes at several parts of the tracing, is not clearly compressed, varying from 18 mm (inspiration) to 13 mm (expiration) in its end-diastolic dimension. Only the right side of the septum is well seen in this tracing. Traces of echoes probably representing the left side of septum can be seen just anterior to the mitral valve (open arrows). The septal substance has been damped out for the purpose of better demonstrating the PE.

Figure 2b—Case 2, postpericardiocentesis of 1040 ml fluid (paper speed 50 mm/sec). The anterior PE has disappeared and the markedly thickened septum now can be appreciated. Respiratory variability of the mitral valve E-F slope has decreased (see Table, p. 514). Mitral valve D-E amplitude increased 6 mm after pericardiocentesis. RV end-diastolic internal dimension increased approximately 10 mm but continued to vary 5 mm during respiration.

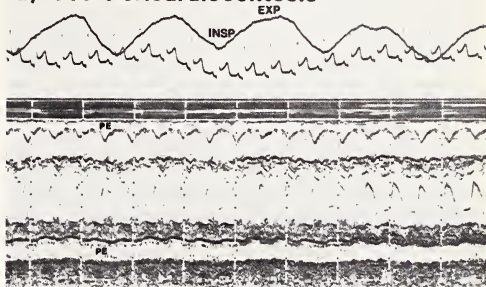
dimensions with respiration and therefore no such recordings were made.

RESULTS

Clinical and echocardiographic findings are indicated in the Table and Figures 1 through 6. In all but case 4, pericardiocentesis was successful in relieving tamponade. In case 4, following a successful initial pericardiocentesis on 8/16/78, fluid rapidly accumulated posteriorly over the next two days but on 8/18/78 could not be aspirated either by subxiphoid or apical approaches. At surgery multiple adhesions were found posteriorly and the entire anterior surface of the heart was adherent to the pericardium preventing any fluid accumulation in this area.

Echocardiographic indications of tamponade were of variable usefulness. In case 1, although the initial tracing (Figure 1a) suggested right ventricular compression, marked swinging of the heart due to mechanical alternans made echocardiographic evaluation difficult. The presence of a prominent anterior as well as posterior effusion was sug-

a) Pre Pericardiocentesis



b) Post 190 ml Pericardiocentesis

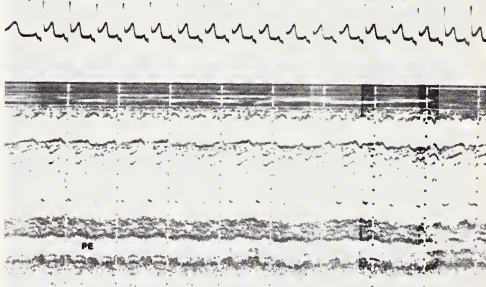


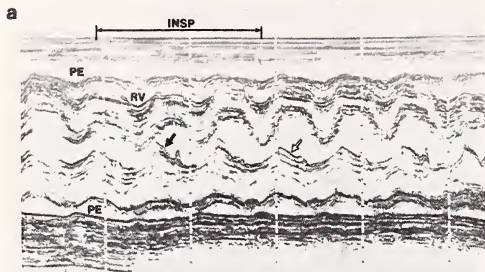
Figure 3a—Case 3. The initial echocardiogram shows anterior and posterior PE. No echocardiographic signs suggesting tamponade are present. Mitral valve E-F slope (not well shown here) varied markedly and was unrelated to respiratory phase.

Figure 3b—After pericardiocentesis the anterior PE has disappeared. Mitral valve E-F slope decreased in amplitude and variability (see Table, p. 514).

gestive of tamponade in five instances but its absence was misleading in the second tamponade involving case 4 when such extensive adhesions rapidly developed anteriorly causing posterior loculation (Figure 5). Accurate measurement of mitral valve E-F slope and D-E amplitude was helpful in case 2 (Figure 2a) but actually misleading in case 4 during his initial episode of tamponade (Figure 4a) when respiratory variations of these measurements were actually the opposite of what has been reported, probably as a result of shifting cardiac position causing a different portion of the valve apparatus to be presented to the ultrasonic beam during different respiratory phases. Following removal of the fluid and relief of the tamponade the situation was reversed and mitral D-E amplitude changes during respiration actually fulfilled the criteria for tamponade expected before pericardiocentesis (Figure 4b, Table, p. 514).

Except in case 3, expiratory compression of the right ventricle seemed the most helpful finding indicating the presence of cardiac tamponade. In cases 2 and 5 the initial expiratory RV internal end-diastolic dimensions did not

RW 49 y/o M 8/16/78
Pre-pericardiocentesis
BP=150-136/98 CVP=31 cm H₂O



Post 920 ml Pericardiocentesis
BP=180-170/110 CVP=18 cm H₂O

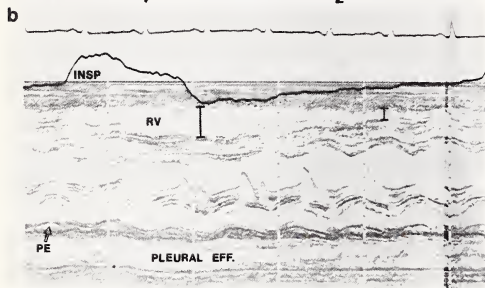


Figure 4a—Case 4 during initial episode of tamponade on 8/16/78 (pneumograph not shown). PE is present anteriorly and posteriorly with severe right ventricular compression during expiration. During inspiration mitral E-F slope and D-E amplitude (solid arrow) actually appear greater than values during expiration (open arrow), the opposite of what might be expected in tamponade.

Figure 4b—Case 4 after pericardiocentesis on 8/16/78. Almost all PE has been removed. Mitral E-F slope was too variable to measure with assurance during phases of respiration but expiratory D-E amplitude was greater than inspiratory, again the opposite of expected result. Respiratory changes in RV dimensions persist although less marked and with less RV compression during expiration than prior to fluid removal. A pleural effusion, confirmed by x-ray is now well seen.

suggest compression but they clearly increased after pericardiocentesis. In case 5, right heart catheterization was performed revealing the characteristic elevation (22 mmHg) and equalization of "pulmonary capillary wedge" and right heart diastolic pressures in cardiac tamponade. In the three instances (cases 2 and 4), where "diagnostic" respiratory changes in ventricular dimensions were present in tamponade they persisted after relief of compression. Systolic notching of the right ventricular epicardium following the QRS in at least 50 percent of the cardiac cycles, as described by Vignola in his patients during tamponade, was seen only in case 5 (Figure 6).⁵

DISCUSSION

In the combined patient material of two previous studies of echocardiography in cardiac tamponade^{3,4} inspiratory mitral E-F slope was diminished in nine of the eleven patients adequately studied, D-E amplitude was reduced in 16 of 17

RW 49 y/o M 8/18/78
BP=154-150/100 CVP=28 cm H₂O

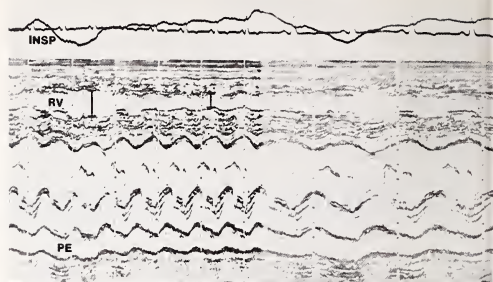


Figure 5—Case 4 in tamponade again two days after initial episode. Compared with post-pericardiocentesis tracing of 8/16 (Figure 4b) there is recurrence of PE posteriorly but RV respiratory dimensional changes are the same and there is no PE anteriorly.

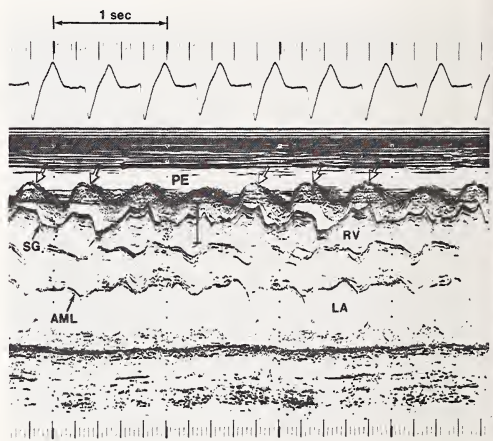


Figure 6—Case 5 during cardiac tamponade. The echocardiographic beam is directed through the anterior mitral leaflet (AML) near its termination at the root of the aorta at the level of the left atrium (LA) where the RV anterior wall epicardial notching (open arrows) could best be demonstrated. .06 seconds after the beginning of the QRS complex which is prolonged because of hyperkalemia and other acid base abnormalities. Only the anterior PE can be seen at this level. The Swan-Ganz catheter (SG) is well visualized in the RV. The right side of the septum is seen only faintly and the RV internal dimension (23 mm) is greater here than at the ventricular level where this measurement is made routinely (15 mm, see Table, p. 514).

and the characteristic respiratory ventricular dimensional changes described were present in 15 of 16. These changes reverted to normal in almost all patients following relief of tamponade. However, in the largest single echocardiographic study of tamponade (17 patients), Schiller and Botvinick⁶ found none of these changes helpful and emphasized instead the finding of right ventricular compression. Although presented primarily to illustrate some of the difficulties in evaluating the echocardiogram in tamponade, our own results would seem to be in agreement with Schiller and Botvinick⁶ and right ventricular compression frequently was

"... clinical findings ..., in combination with the echocardiographic picture, can make the diagnosis relatively easy even when the echocardiogram is not totally convincing."

"... Central venous pressure is invariably elevated and pulsus paradoxus present in approximately 85 percent of such cases."

found also among the cases reported by Settle *et al.*⁴ Although the degree of right ventricular compression was generally greater in the group studied by Schiller and Botvinick⁶ than found by us and Settle⁴, this undoubtedly is due to the stringency of the Schiller criteria for tamponade (systolic blood pressure less than 100 mg Hg). Recent experimental data concerning echocardiography and cardiac tamponade indicate that, due to individual variability, no absolute minimal value for normal right ventricular dimension is likely to prove helpful in making this diagnosis.¹¹ Rather, reductions from preexisting RV dimensions are to be emphasized as demonstrated in our cases 2 and 5 and possible respiratory changes in right and left ventricular dimensions as well. In addition to the newer criteria described, we believe that significant amounts of fluid anteriorly as well as posteriorly should alert one to larger effusions with, therefore, a greater possibility of tamponade, as previously reported.^{4,12}

Because cardiac tamponade is not a frequent hospital occurrence, as with all current studies of echocardiography and tamponade, our limited experience only can serve to add to the experience of previously published investigators, point out some of the pitfalls involved, and provide what seem to be best current guidelines. Whatever the current status of the echocardiographic features of tamponade, most important to be appreciated are the clinical findings that, in combination with the echocardiographic picture, can make the diagnosis relatively easy even when the echocardiogram is not totally convincing. Central venous pressure is invariably elevated and pulsus paradoxus present in approximately 85 percent of such cases.^{5,9,13,14} Rarely confirmation of the diagnosis can be obtained by right heart catheterization and demonstration of elevation and equalization of "pulmonary capillary wedge," pulmonary artery diastolic, right ventricular end-diastolic and mean right atrial pressures, as illustrated by one of our own cases in which invasive hemodynamic evaluation was considered necessary prior to performing therapeutic pericardiocentesis.

Recently suggested criteria for the M-mode echocardiographic diagnosis of cardiac tamponade were evaluated in six instances (five patients) of this disorder. In most cases, evaluation of echocardiographic data, even when not completely confirmatory, allows for proper diagnosis when considered with associated clinical findings.

SUMMARY

Although M-mode echocardiography has become the mainstay in the diagnosis of pericardial effusions, specific echocardiographic criteria for the diagnosis of cardiac tam-

ponade complicating pericardial effusion remain to be fully defined.

Echocardiographic findings proposed to suggest tamponade have included changes in mitral valve appearance, respiratory changes in ventricular dimensions, right ventricular compression or free wall systolic notching and prominence of anterior effusion. To evaluate the utility of these criteria along with clinical findings, six episodes of tamponade in five patients are reported. Echocardiographically, findings of right ventricular compression and the presence of prominent anterior effusions were the most helpful in making the diagnosis of tamponade. Where diagnosis of tamponade may be in doubt the clinical findings of venous hypertension, pulsus paradoxus, or systemic hypotension invariably can be of assistance in reaching the correct diagnosis.

REFERENCES

1. Elder I: Diagnostic use of ultrasound in heart disease. *Acta Med Scand* 191: 308-326, 1955.
2. Feigenbaum H, Waldhausen JA, Hyde LP: Ultrasound diagnosis of pericardial effusion. *JAMA* 191: 711-714, 1965.
3. D'Cruz IA, Cohen HC, Prabhu R, Glick G: Diagnosis of cardiac tamponade by echocardiography. *Circulation* 52: 450-465, 1975.
4. Settle HP, Adolph RJ, Fowler NO, Engel P, Agruss NS, Levenson NI: Echocardiographic study of cardiac tamponade. *Circulation* 56: 951-959, 1977.
5. Vignola PA, Pohost GM, Curfman GD, Meyers GS: Correlation of echocardiographic and clinical findings in patients with pericardial effusions. *Am J Cardiol* 37: 701-706, 1976.
6. Schiller NB, Botvinick EH: Right ventricular compression as a sign of cardiac tamponade. *Circulation* 56: 774-779, 1977.
7. Martin RP, Rakowski H, French J, Popp RL: Localization of pericardial effusion with wide-angle phased-array echocardiography. *Am J Cardiol* 42: 904-921, 1978.
8. Kotler MN, Mintz GS, Segal BL, Parry WR: Clinical uses of two-dimensional echocardiography. *Am J Cardiol* 45: 1061-1082, 1980.
9. Lange RL, Botticelli JT, Tsagaris TJ, Walker JA, Gani M, Bustamante RA: Diagnostic signs in compressive cardiac disorders. *Circulation* 33: 763-777, 1966.
10. Horowitz MS, Schultz CS, Stinson EB, Harrison DC, Popp RL: Sensitivity and specificity of echocardiographic diagnosis of pericardial effusion. *Circulation* 50: 239-247, 1974.
11. Martins JB, Kerber RE: Can cardiac tamponade be diagnosed by echocardiography? *Circulation* 60: 737-742, 1979.
12. Feigenbaum L: *Echocardiography*, 2nd Edition. Philadelphia, Lea and Febiger, 1976, pp 427.
13. Symes JC, Berman ND: Early recognition of cardiac tamponade. *Can Med Assoc J* 23: 863-864, 1977.
14. Reddy PS, Curtiss EI, O'Toole JD, Shaver JA: Cardiac tamponade: Hemodynamic observations in man. *Circulation* 58: 265-272, 1978.

for "cardiac separation"...



Although over 80% of post-coronary patients can resume normal marital sexual activity, fear of anginal pain often results in "cardiac separation" between patients and their families.

You can help minimize "cardiac separation" with a program of

counseling and often, with a prescription for Cardilate® (erythrityl tetranitrate).

Cardilate® increases exercise tolerance, helps patients return to more normal levels of activity—including sexual activity.

Sublingually, Cardilate begins to

work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to 2 hours.

counsel &
Cardilate®
(erythrityl tetranitrate)

CARDILATE® (ERYTHRITYL TETRANITRATE)

INDICATIONS: Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

CONTRAINDICATIONS: Idiosyncrasy to this drug

WARNING: Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Intraocular pressure is increased; therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspira-

tion and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION

Oral/Sublingual Tablets: Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg, prior to each anticipated physical or emotional stressor, for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED:

CARDILATE (Erythrityl Tetranitrate) TABLETS (Scored)
for ORAL or SUBLINGUAL USE 5 mg, Bottle of 100;
10 mg, Bottles of 100 and 1000; 15 mg, Bottle of 100

Reference: 1. Hellerstein HK, Friedman EH. Sexual activity and the postcoronary patient. Arch Intern Med 125:987, 1970.

Burroughs Wellcome Co.,
Research Triangle Park, North Carolina 27709



Preadmission Evaluation and Elective Cataract Surgery*

BARRY A. MALTZMAN, M.D., ALFONSE A. CINOTTI, M.D. and
JOSEPH P. CALDERONE, JR., A.B., Jersey City

Routine preadmission evaluation has become one of many targets in the battle to curb medical costs. Controversy centers around cost benefit considerations of such evaluation. Preadmission findings in two hundred out of four hundred cataract extractions performed at an urban hospital were examined. Forty-four patients (22 percent) were found to have newly diagnosed ailments which would have remained undetected were it not for preadmission tests. The cost of this evaluation is discussed along with changes in its indication.

Recent controversy has arisen over the medical and economic value of standard preadmission evaluation for elective surgical procedures. The major criticisms are that chest x-rays, electrocardiograms, medical consultations, and a variety of laboratory tests, when performed routinely without medical indications, yield negative results and increase specific costs. When the results are abnormal, they usually are associated with previously known disease, or are sufficiently insignificant that surgical plans remain unaltered. However, not all standard evaluation yields unremarkable results.

This paper reviews the question of whether the incidence of significant presurgical findings is sufficiently high to merit the cost of subjecting all prospective elective surgical patients to the rigors of preadmission evaluation.

The elective surgery studied was cataract extraction. This type of surgery often is done under local anesthesia in ambulatory patients. It is relatively non-invasive and highly elective. This paper reviews the findings and usefulness of normal preadmission evaluation of patients scheduled for cataract extraction in an urban hospital.

METHODS

Four hundred (400) cataract extractions were performed at Jersey City Medical Center during the period 1977-1978. The complete hospital records of two hundred (200) of these were chosen at random by computer for retrospective examination

of preadmission findings. Those elements of preadmission testing examined were sequential multiple analysis (SMA₆), complete blood count (CBC), urinalysis, chest roentgenogram (x-ray), and electrocardiogram (ECG), in addition to the patient's history and physical examination performed by a medical internist. These procedures were performed routinely on all of the patients regardless of their past or present medical histories. Any new diagnosis based on preadmission findings was noted.

RESULTS

Of the 200 patients in the study, 51 had no disorders other than cataracts (25 1/2 percent), 137 had previously known chronic ailments (68 1/2 percent) and 44 were found on presurgical evaluation to have 58 newly discovered disorders (22 percent).^b In 31 of these 44 patients, laboratory tests, ECG

*This study is from the Jersey City Medical Center where Dr. Maltzman is Director of the Eye Clinic and Dr. Cinotti is Director of Ophthalmology. Dr. Cinotti is Professor and Acting Chairman, Department of Ophthalmology, New Jersey Medical School, CMDNJ and Dr. Maltzman is Clinical Associate Professor of Ophthalmology at the same institution. Mr. Calderone is a third-year medical student at the College. Correspondence may be addressed to Dr. Maltzman at the Jersey City Medical Center, 30 Baldwin Avenue, Jersey City, NJ 07304.

^aCl 95-106, Co₂ 24-32, K 3.5-5.3, Na 135-147, BUN 8-20, Glucose 65-110. The figures represent normal values.

^bPercentages add up to more than 100 due to patients with multiple disorders.

Table 1
Types of Disorders

Type	# of Cases
Cardiac	14 (7%)
Diabetes Mellitus	8 (4%)
Hypertension	7 (3.5%)
Pulmonary	7 (3.5%)
Anemia	5 (2.5%)
Inguinal Hernia	4 (2%)
Hepatomegaly	4 (2%)
Other (venous insufficiency, urinary tract infection, electrolyte imbalance)	9 (4.5%)
Total	58

Table 2
Diagnoses Per Procedure

Test	# of Patients with new Diagnosis
Urinalysis	11 (5.5%)
SMA ₆	10 (5%)
ECG	7 (3.5%)
X-ray	6 (3%)
CBC	5 (2.5%)
History and physical examination (Medical Consultation)	22 (11%)

and x-ray were critical in making the diagnosis. The remaining 13 patients had abnormalities diagnosed by physical examination (medical consultation). Included among the 58 disorders were the following: cardiac abnormalities (including murmurs, arrhythmias, cardiomegaly) and congestive failure, all of varying degrees of severity, diabetes mellitus, hypertension, pulmonary abnormalities such as emphysema and bronchitis, anemia, hepatomegaly, inguinal hernias, other abnormalities, including venous insufficiency, urinary tract infections and electrolyte imbalances. (Table I). These diagnoses were made by a consulting medical internist after performing a physical examination and studying the results of the five preadmission tests in question. (Table II).

Urinalysis was influential in diagnosing disorders in eleven patients, the SMA₆ in ten patients, ECG in seven patients, x-ray in six patients, and CBC in five patients. Patient history and physical examination (medical consultation) yielded new diagnoses in 22 patients. If urinalysis, SMA₆, ECG, x-ray and CBC are considered as separate tests for each of the 200 patients, then 1000 test results were examined in the study, and 39 of them (3.9 percent) were useful in the diagnosis of new disorders in 31 patients (15.5 percent).

DISCUSSION

Forty-four of the 200 patients had previously undiagnosed disorders (22 percent). It appears that the time and expense invested in the detection of these ailments has some worth, for had such detection not been attempted a significant number of ailments would have remained undiagnosed. From the data gathered, the history and physical examination (medical consultation) proved to be the most fruitful phase of preadmission evaluation, responsible for diagnosis in 22 patients (11 percent of the 200 studied.)

Although only 39 of the 1000 preadmission tests led to new diagnoses, these results led to the diagnosis in 15.5 percent of the patients (31 out of 200). Furthermore, each of the five tests (SMA₆, CBC, urinalysis, x-ray, ECG) appeared equally important in uncovering new disease, so that none of the five should have been eliminated (i.e., in order to decrease health care costs). Therefore, the latter incidence (31 patients out of 200, opposed to 39 tests out of 1000) is the more accurate statistic denoting the usefulness of the five tests in question.

It should be noted that the computer selected charts of patients who actually had undergone cataract surgery and who were, therefore, sufficiently healthy to undergo such surgery. A number of patients were excluded from the study because ominous preadmission findings cancelled their surgery. This selection criterion biases the data and makes the preadmission testing appear less important and is actually understated by the data.

COMMENT

One can conclude that the health of a patient about to undergo an elective procedure such as a cataract extraction cannot be taken for granted. The most important presurgical evaluation is a competently performed physical examination. The results show that such an examination was more important than any one of the five tests in the study, and nearly as important as all five. However, the conclusion that the other five tests are not worthwhile is an erroneous one. Elimination of these preadmission tests would lead to a decline in the level of medical care in that a substantial number of disorders would remain undiagnosed.

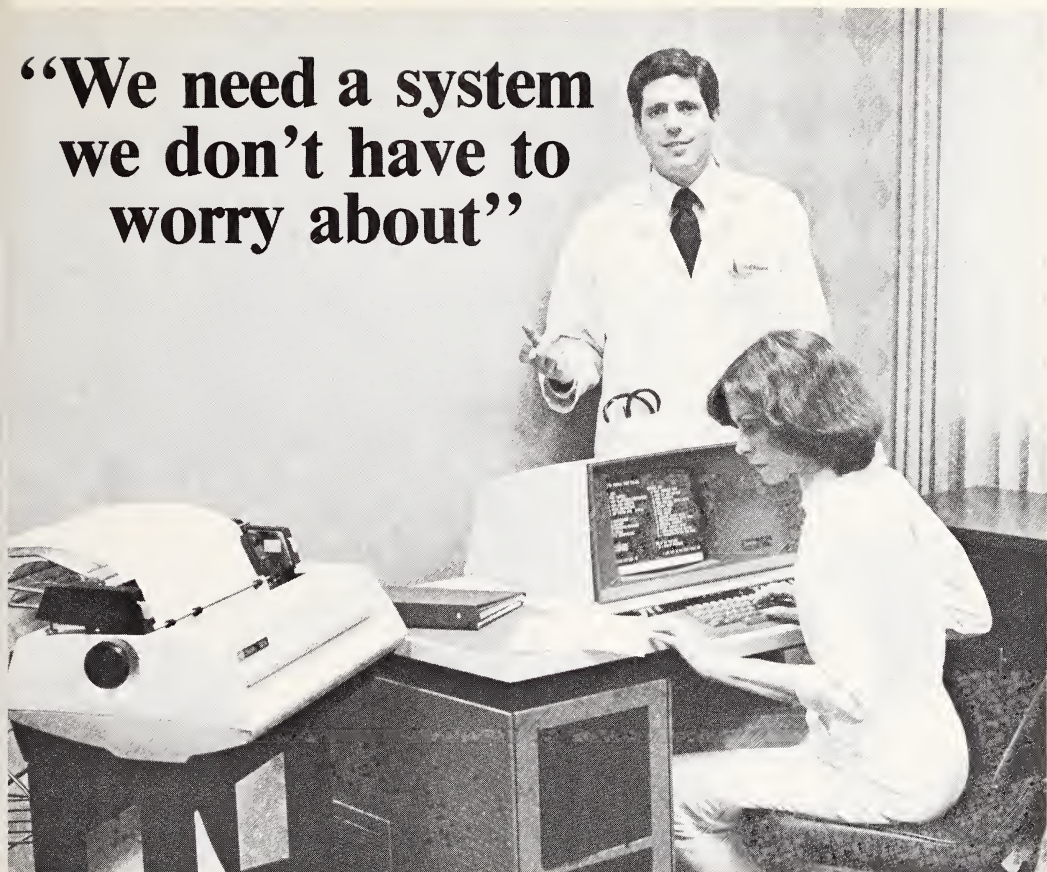
The importance of presurgical evaluation is not being questioned as much as the cost of such evaluation. The attempt to measure the value of presurgical testing by means of economic standards is alien to the health profession. However, government, third party health care providers, and many medical institutions are raising the possibility that the health care dollar is shrinking. Therefore, scrutinization of such expenditures is in order.

In most hospitals preadmission testing must occur within three to six days prior to the surgical procedure. One instance in which costs might be reduced is when the prospective surgical patient has undergone some form of testing within the immediate past. If such tests are sufficiently recent, they can be obtained and substituted for standard preadmission tests. Thus, medical costs could be decreased.

These tests have evolved through years of trial and proven results. At a time when the medical profession is being criticized for its cure-instead-of-care, treat-the-disease-instead-of-the-patient approach, eliminating procedures as potentially beneficial to the patient's overall health as preadmission evaluation would be a serious mistake. A pilot study of such a small size cannot even begin to measure the true value of such evaluation. Perhaps the area of cost containment to be explored is the relaxation of time requirements for laboratory testing. An in-depth, prospective study comparing the results of preadmission evaluation in elective surgical patients with previously existing laboratory, x-ray, and ECG data should be taken. Such a study could evaluate data obtained at intervals of one week, one month, three months, and six months prior to surgery, and in particular, develop a correlation with the patient history and physical examination possibly leading to a wide acceptance of routine preoperative medical consultations.

Lastly, the medical-legal aspect of presurgical evaluation has not been considered. This area needs redefining if the medical profession continues to be "economized" through regulation.

"We need a system we don't have to worry about"



Dr. I. David Weisband, of the Regional Orthopedic Professional Association, is one of a growing number of physicians who've found Minicom's Medical Practice Management System meets the unique needs of a medical practice.

Automatic preparation of statements, Medicare and insurance company forms; instantaneous, up-to-the-minute accounts receivable information, plus a variety of practice analysis reports.

"We treat patients, not computers," Dr. Weisband says, "so we need a system we don't have to worry about."

And our Medical Practice Management System is just that. It

features reliable Xerox Diablo equipment and is backed by our policy of Unsurpassed Service—hardware, software, training, maintenance and system back-up, all from one reliable source.

"Our office manager and accounting firm investigated alternatives," he continues, "and recommended the Minicom system as the best solution to our needs. I agree."

So, before you invest in a computer system for your practice, take his advice. Look into our Medical Practice Management System. Drop the coupon in the mail, or give us a call...and ask about US!

I'd like more information on Minicom's Medical Practice Management System.

Name

Address

City, State, Zip

Telephone (Area Code) MN1



MINICOM

1415 E. Marlton Pike,
Cherry Hill, N.J. 08034
(609) 429-0600
(215) 925-6908

UNSURPASSED SERVICE

Distributors of Xerox business and professional computer systems.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration of excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android[®] / 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. mg. mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Acetaminophen Overdose

GEORGE W. MILLER, JR., M.D., Montclair*

Acetaminophen is a commonly used medication in the home today. Overdose presents a quantity of acetaminophen too great for rapid detoxification of its metabolites in the liver. These metabolites are then free to damage liver cells unless antidote is given within 12 hours of ingestion.

Acetaminophen is a common antipyretic, analgesic medication used in the home today. At present, it is marketed in over two hundred preparations, and parenteral preparations can be expected in the future. It has been advertised and accepted by the public as a more safe, less toxic alternative to aspirin. Although aspirin is still a leading cause of poisoning, acetaminophen poisoning has been increasing.^{3,7} The following case report is an example of acetaminophen overdose.

CASE REPORT

A fourteen-year-old female was admitted to the hospital four hours after ingesting forty-two Extra-Strength Tylenol® (approximately twenty grams). She became depressed by problems at home. She denied symptoms of nausea, vomiting, diaphoresis and anorexia. She had no past history of hepatitis, liver disease, drug abuse or kidney disease. Her temperature was 97 degrees F., pulse 80 and regular, respirations 20 and regular, and blood pressure 122/78. She appeared in no acute distress and was awake, ambulatory and completely oriented. Bowel sounds were present. The abdomen was soft, non-tender and without organomegaly. Acetaminophen levels taken four, eight, and sixteen hours postingestion were 188, 98, and 12 micrograms per ml., respectively. The patient was lavaged in the emergency room and given a loading dose of 7.5 grams N-acetylcysteine (Mucomyst®) via nasogastric tube. Undiluted N-acetylcysteine in a dose of four grams was given via nasogastric tube

at four-hour intervals for 17 maintenance doses. The patient's prothrombin time, blood urea nitrogen, total bilirubin, SGOT, SGPT, LDH and alkaline phosphatase remained normal during her hospital stay. She was seen by a psychiatrist and referred to a family counseling clinic prior to her discharge from the hospital.

METABOLISM

Absorption of acetaminophen is rapid following oral or rectal administration. Peak plasma levels are reached in forty to sixty minutes. The rate of absorption is increased with alcoholic solutions and increased gastric motility. Gastric absorption of acetaminophen is slow, and agents which decrease gastrointestinal motility delay absorption.^{1,3}

Acetaminophen is an active metabolite of phenacetin via the liver microsomal enzyme pathway involving O-dealkylation.^{1,3,5} It is metabolized in the liver to conjugated sulfates, glucuronides, and mercapturates. Two studies have shown that acetaminophen is excreted in the urine as follows:

Free acetaminophen	2.1%	(1%)
Sulfate conjugate	52.1%	(34%)
Glucuronide conjugate	42. %	(63%)
Mercapturic conjugate	3.8%	(-)
Cysteine conjugate	-	(3%)

Neonates and children excrete sulfate conjugates due to

*Dr. Miller is a resident in family practice in the Mountainside Hospital Family Practice Program which is affiliated with the New Jersey Medical School, CMDNJ. He may be addressed at 77 Grove Street, Apt. 8F, Montclair 07042.

“Antihistamines, phenobarbital, phenytoin, diethylstilbestrol, ethacrynic acid, malnutrition and a negative nitrogen balance increase the toxicity of acetaminophen.^{3,4,5}”

“Death is frequently preceded by anuria and coma and is related to hepatic failure.”

their limited ability to metabolize by glucuronidation.^{3,5}

Twenty-five per cent of acetaminophen is metabolized on the first pass through the liver and does not reach the general circulation. The half-life of acetaminophen at therapeutic plasma levels is two to four hours. Its metabolism is according to zero order kinetics. The half-life has increased to as much as eight hours in individuals with liver disease or hepatotoxic plasma acetaminophen levels. There is no change in half-life with renal disease.^{1,3}

At normal therapeutic blood levels of five to twenty-five micrograms per ml.^{1,7} acetaminophen is metabolized to intermediates by the hepatocyte mixed-function oxidase-cytochrome P₄₅₀ system.⁴ The intermediates are rapidly detoxified by reaction with the sulfhydryl side chain of intracellular glutathione. The resultant cleavage of the glutathione molecule produces mercapturic conjugates.^{2,11}

TOXIC EFFECTS

When acetaminophen is ingested in greater than therapeutic quantities, the glutathione detoxification pathway is overwhelmed. The excess acetaminophen metabolites produced by the mixed-function oxidase system directly produce liver cell damage.^{2,11} Acetimidoquinone and N-acetyl-p-benzoquinone are believed to be the toxic metabolites and alkylating agents which combine with nucleophilic liver cell macromolecules leading to cell death.^{1,13}

Drugs which stimulate the cytochrome P₄₅₀ system increase hepatotoxicity; drugs which block this pathway prevent hepatotoxicity. Antihistamines, phenobarbital, phenytoin, diethylstilbestrol, ethacrynic acid, malnutrition and a negative nitrogen balance increase the toxicity of acetaminophen.^{3,4,5}

CLINICAL PICTURE

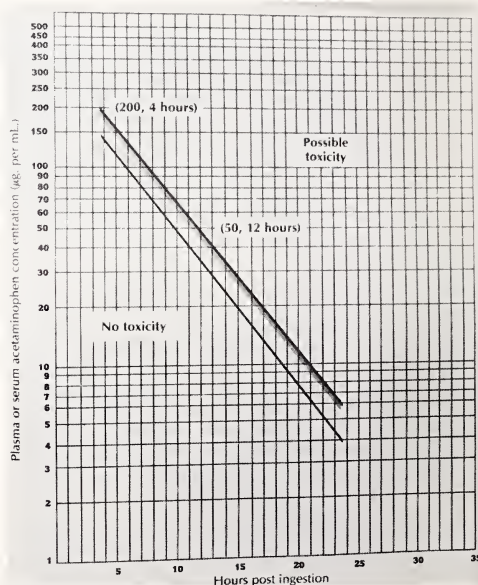
Symptoms and signs of acetaminophen poisoning may be delayed three to five days. Patients experience sweating, nausea, vomiting and anorexia within a few hours following ingestion. They may experience malaise but CNS depression is a rare feature. After 24 hours, these symptoms disappear. Right upper quadrant abdominal pain may be present due to hepatic damage. Liver enzymes and bilirubin become elevated with abnormal blood chemistries. Prothrombin time becomes prolonged. Renal function may deteriorate but blood urea nitrogen stays low due to decreased liver urea production. The sequelae of hepatic necrosis follows at three to five days. There may be coagulation defects, jaundice, renal failure, and myocardial pathology. EKG may show ST segment abnormalities and T wave flattening. There may be subendocardial hemorrhage and myocardial necrosis, proximal and distal tubular necrosis and papillary necrosis (rare). Liver biopsy reveals centrilobular necrosis with long-term increase in fibrous tissue but not cirrhosis. Death is frequently preceded by anuria and coma and is related to hepatic

failure. Hemodialysis has not been valuable in preventing hepatic injury.^{2,11,13}

PROGNOSIS

The prognostic indicators of acetaminophen poisoning include: (1) the amount of acetaminophen ingested, (2) the serum acetaminophen level, and (3) the serum acetaminophen half-life. At a half-life greater than four hours or a plasma level of acetaminophen greater than 300 micrograms per ml. at four hours postingestion, there is almost always hepatotoxicity with mortality as high as 20 percent. A plasma level between 150 and 300 micrograms per ml. at four hours postingestion is associated with minimal to moderate liver damage but rarely mortality. A plasma level less than 150 micrograms per ml. at four hours postingestion indicates minimal or absent liver damage (see figure).^{3,5,13}

Hepatotoxicity and death have not been reported in children below the adolescent age group, despite the occurrence of significant ingestions.^{3,4} It is speculated that many cases of acetaminophen poisoning are missed because



Figure—Nomogram: Plasma or serum acetaminophen concentration vs time post-acetaminophen ingestion. (Reproduced with permission from “Management of Acetaminophen Overdose with N-Acetylcysteine,” a pamphlet from McNeil Consumer Products Company.)

*Adapted from Rumack BH and Matthew H: *Pediatr* 55:871-876, 1975.

"Treatment consists of: (1) lavage only when . . . acetaminophen ingestion alone; (2) lavage . . . charcoal, magnesium sulfate for mixed ingestion; charcoal must be lavaged out . . . it inactivates N-acetylcysteine; (3) give N-acetylcysteine orally."

pediatricians do not relate the clinical findings of poisoning three to five days after ingestion with accidental ingestion of significant amounts of acetaminophen elixir.⁴

TREATMENT

The criteria for the use of the Rocky Mountain Poison Control Center (RMPCC) protocol^{3,6} in acetaminophen poisoning is as follows: (1) ingestion of 7.5 grams or more by history, (2) knowledge of the time of ingestion within two hours, and (3) presence of a serum level above 150 micrograms per ml. at four hours postingestion. Informed consent must be obtained since N-acetylcysteine is still an experimental drug. This represents the only approved treatment in this country and RMPCC has the federal investigation number. Use of this protocol requires release of the hospital chart copy to RMPCC.

Treatment consists of the following: (1) lavage only when there is acetaminophen ingestion alone; (2) lavage and give charcoal, magnesium sulfate for mixed ingestion; charcoal must be lavaged out because it inactivates N-acetylcysteine; (3) give N-acetylcysteine orally. The loading dose is 140 mg. per kilogram of a 20 percent solution. The maintenance dose is 70 mg. per kilogram of a 20 percent solution every four hours for 17 doses. The 20 percent solution should be diluted three to one when given orally but need not be diluted when given via nasogastric tube. The ten percent solution should be diluted one to one. Diluents include cola and orange or grapefruit juices.

The patient is kept without food and drink one hour before and one hour following the administration of antidote. If the patient vomits within one hour of the dose, repeat the dose. If the patient vomits after one hour, go to the next dose. For persistent vomiting, a Miller-Abbott tube can be used.

Acetaminophen levels should be drawn at four hours if the level will be known in two hours or every four hours if the level is not available for several hours or days. RMPCC recommends obtaining two or three acetaminophen levels. Laboratory data should include a pregnancy test when

applicable and also SGOT, SGPT, total bilirubin, blood urea nitrogen and prothrombin time every 24 hours. Additional items include vital signs every four hours, diet and activity as tolerated and avoidance of all other medications.⁶

FOLLOWUP

If the patient is non-toxic, repeat the liver function tests at 48 hours. If the patient is toxic and liver function tests are elevated, monitor him daily or until normal or returning to normal. If the patient is toxic and the liver function tests are not elevated at the end of the third day, no followup is required. If there are any problems, the RMPCC can be reached at 800-525-6115.⁶

SUMMARY

Acetaminophen is a common antipyretic, analgesic medication with rapid oral and rectal absorption. Poisoning overloads the rapid detoxification of toxic metabolites of acetaminophen by reaction with intracellular hepatic glutathione. These metabolites are then free to bind nucleophilic hepatocellular macromolecules leading to cell death. N-acetylcysteine provides sulfhydryl groups for reaction with metabolites and thus averts hepatic necrosis. The case report is presented to illustrate the treatment of acetaminophen poisoning.

REFERENCES

1. Gilman AG *et al*: *The Pharmacological Basis of Therapeutics*. New York, Macmillan, 1980, pp. 701-705.
2. Rumack BH, *et al*: Acetaminophen overdose: Incidence, diagnosis and management in 416 patients. *Pediatr* 62 (Suppl):898-903, 1978.
3. Peterson RG, *et al*: *Acetaminophen Poisoning*. Denver, Rocky Mountain Poison Control Center, 1980.
4. Rumack BH, *et al*: Acetaminophen poisoning and toxicity. *Pediatr* 55:871-876, 1975.
5. Bailey BO: Acetaminophen hepatotoxicity and overdose. *Am Fam Phys* 22:83-87, 1980.
6. *Acetaminophen Initial Contact Form*, Denver, Rocky Mountain Poison Control Center, 1980.
7. Amerer B, *et al*: Acetaminophen. *Ann Intern Med* 87:202-209, 1977.
8. Peterson RG, *et al*: Treating acute acetaminophen poisoning with acetylcysteine. *JAMA* 237:2406-2407, 1977.
9. Prescott LF: Treatment of paracetamol (acetaminophen) poisoning with N-acetylcysteine. *Lancet* (Aug 27) 432-434.
10. Prescott LF, *et al*: Intravenous N-acetylcysteine: The treatment of choice for paracetamol poisoning. *Br Med J* 2:1097-1100, 1979.
11. Committee on Drugs, American Academy of Pediatrics: Commentary on acetaminophen. *Pediatr* 61:106-112, 1978.
12. Blair D, *et al*: Acetaminophen in serum and plasma estimated by high-pressure liquid chromatography: A micro-scale method. *Clin Chem* 23:743-745, 1977.
13. Vaughan VC, *et al*: *Textbook of Pediatrics*. Philadelphia, Saunders, 1979, pp. 2012-2013.

**KATE MACY LADD
CONVALESCENT HOME
Far Hills, N.J.**

*Under the terms of the Will of the late
Walter G. Ladd we provide*

**"Skilled Convalescent Care
Without Charge"
To
Ambulatory Female Patients.**

Inquiries to:
Newark Office—744 Broad St.
Newark, N.J. 07102
For all information
Tel: (201) 622-1484
Over 20,000 admissions
since 1949

Barry L. Mills, FACNHA, LNHA
Administrator

Don T. Van Dam, M.D., DABFP
Medical Director

June Open Enrollment!!! Doctors: There's still time to sign up for group major medical!

**BROAD COVERAGE FOR MEMBERS
PARTICIPATING IN BASIC
GROUP BLUE CROSS/BLUE SHIELD PROGRAMS**

Officially Endorsed by the Medical Society of New Jersey

For More Information Contact:

DONALD F. SMITH & ASSOCIATES

One Airport Place, Route 206 North, PO Box 2197 Princeton, New Jersey 08540 (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross / Blue Shield

Trends in Cancer Mortality in New Jersey—Comparison of Geographic Distribution in 1950-1969 and 1969-1975*

I.S. THIND, M.D., G.R. NAJEM, M.D., I. COHEN, B.S.,
R. LEVY, D.B. LOURIA, M.D. Newark

Comparison of 1950-1969 with 1969-1975 cancer mortality showed an increase for the state of New Jersey for three ethnic and sex groups, particularly among black men. The increase was not uniformly distributed when analyzed by county of residence. In general, northeastern counties experienced no change or slight decline, whereas the so-called rural counties experienced the most increase. Furthermore, different counties were involved with different ethnic and sex groups.

Mason and McKay analyzed the cancer mortality for all counties of the United States for the years 1950-1969.¹ This comprehensive analysis indicated that New Jersey had the greatest cancer burden in the country during this 20-year period. Further analysis of the same data showed that: (a) cancer mortality rates more than 50 percent above the national average were confined to a minority of New Jersey's 21 counties, namely Hudson, Essex and Passaic for whites and among blacks the counties were Hudson, Passaic, Bergen, Middlesex, Hunterdon, Ocean and Sussex, (b) county cancer death rates 50 percent below the national average occurred far less frequently than death rates 50 percent above the national average and (c) comparison of the 21 New Jersey counties with each other showed that Hudson, Passaic, Bergen and Middlesex, all geographically in the northern part of the state, ranked in the top ten New Jersey counties for all four ethnic and sex categories.²

To update the county-based cancer mortality rates in New Jersey and to assess geographic trends over time, we compared the New Jersey cancer mortality experience for the years 1969-1975 with the 1950-1969 data.

METHODS

Mortality tapes for the years 1969-1975 were obtained from the Center for Health Statistics, Bethesda, Maryland. Average annual age specific cancer mortality rates for the years 1969-1975 by ethnicity, sex and county of residence

were used to calculate age-adjusted rates by the direct method, using the 1960 U.S. population as a standard.³

For each county, the observed age-adjusted average annual rate of mortality for 1969-1975 was compared with the expected rate based upon the increase in the state since 1950-1969. The expected mortality rate for 1969-1975 in each county was calculated as follows: the ratios of New Jersey's overall 1969-1975 mortality rate to its 1950-1969 rate was multiplied by the 1950-1969 county rate; we then divided the rate observed for 1969-1975 by the rate expected for this period and tested the quotient for statistical significance assuming Poisson distribution according to the Bailar and Ederer formula.⁴

RESULTS

Comparison of the average annual age-adjusted total cancer mortality in New Jersey for 1969-1975 with 1950-1969 experience (Table 1) showed that: (a) increase in rate was found in three race-sex groups, (b) the male rates continue to be strikingly higher than female rates for each race, (c) the rates for males increased more than for females, (d) the black males had the highest percentage increase and (e) the rates increased more for blacks than whites for both sexes.

We used the Bailar and Ederer formula to assess the

*From the Department of Preventive Medicine and Community Health, College of Medicine and Dentistry of New Jersey, New Jersey Medical School, Newark. Correspondence may be addressed to Dr. Thind at the College—100 Bergen Street, Newark, NJ 07103.

Table 1
Age-Adjusted Average Annual Cancer Mortality
in New Jersey*

Race and Sex Group	1950-1969**	1969-1975**	Percent Change#
White Males	205.0	215.9	5.31
White Females	147.9	147.1	-0.54
Black Males	230.3	274.1	19.01
Black Females	163.4	167.4	2.44

*Deaths per 100,000 persons adjusted to 1960 U.S. population

**Average annual age specific rates based upon 1960 and 1970 New Jersey census population for time period 1950-1969 and 1969-1975 respectively were used to calculate age-adjusted rates.

Percent change $\frac{(1969-1975 \text{ rate}) - (1950-1969 \text{ rate}) \times 100}{(1950-1969 \text{ rate})}$

significance of fluctuations in total cancer mortality rates in individual counties (Figure 1).⁴ The individual county analysis showed that among white men statistically significant increase occurred in seven counties, statistical decrease in four counties and no change in the ten remaining counties. The corresponding figures for women were: increase in seven, decrease in three and no change in eleven counties. The county pattern for white males and females was different (Figure 1). Black males showed statistically significant increase in three counties, decrease in five and no change in ten counties (the number of cases was too small in three counties to draw any conclusions). In this analysis, no significance tests of fluctuations were done if the number of cases per county per year was less than seven. Among black women statistically significant increase was found in three counties,

decrease in two and no change in ten counties; data in six counties could not be analyzed because of the low number of cases. Again as with whites, the counties showing increases or decreases were not identical for men and women.

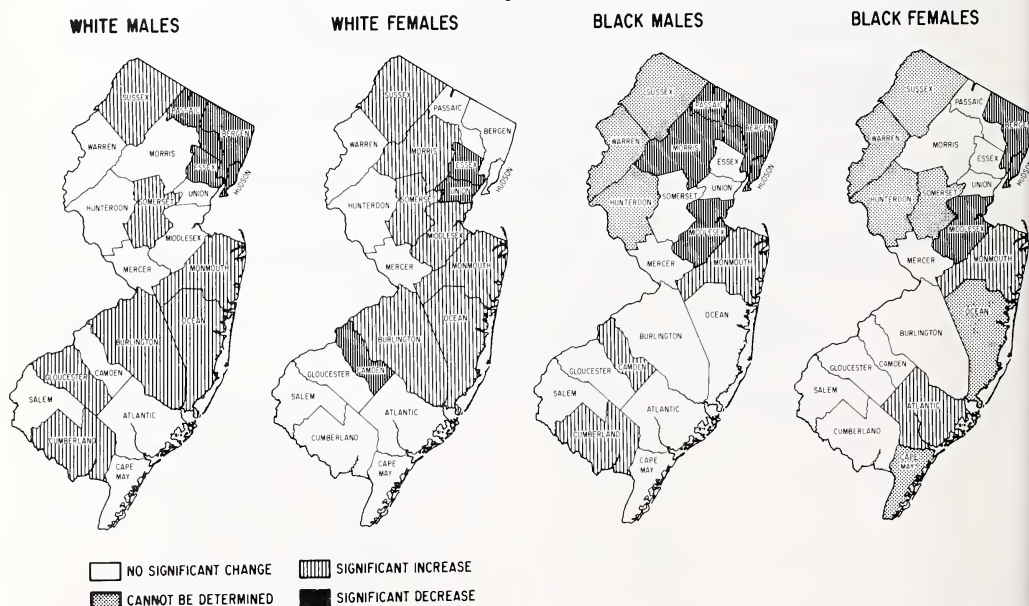
Of 84 possible county changes, increase occurred in 20 instances, decrease in 14 and no change in 41 instances. In nine instances no judgment was possible.

Only in Monmouth county, situated in the middle of the state, were significant increases found for all four ethnic sex groups. Of the four counties with the highest rate in 1950-1969,² Bergen and Hudson counties experienced a statistically significant decline for men (white and black) and for black women. Middlesex county showed no change for white men, increase for white women and decrease for black men and women. Passaic county showed a decrease for white and black men and no change among women of both races.

As shown in Figure 1, white men experienced a statistically significant decrease for 1969-1975 in cancer rates in the high density, heavily industrialized northeastern counties. The significant increase in cancer mortality among white women was not primarily in the industrialized northeastern counties, which showed either no change or decreased mortality. Like whites, the blacks in the northeast counties had either no change or statistically significant reduction in rates.

The northeast counties (high population density and heavily industrialized) present the most intriguing cancer mortality pattern, namely, a statistically significant decrease in mortality or no change for all four ethnic and sex groups as compared to the previous years studied. Furthermore, the data in Figure 1 show an upward trend in the so-called rural counties and counties along the Atlantic Ocean; this is particularly true for white men and women.

Figure 1



The expected rates for each county were calculated as described in methods.

Statistically significant increase or decline compared to the expected rate for each county was based upon using 95 percent confidence limits, calculated according to Bailar and Ederer⁴

If number of cases was less than seven per year, no tests for statistical significance were done.

"The northeast counties (high population density and heavily industrialized) present the most intriguing cancer mortality pattern ..."

"... the data ... show an upward trend in the so-called rural counties and counties along the Atlantic Ocean ..."

DISCUSSION

We found an increase in cancer mortality for the years 1969-1975 compared to the 1950-1969 period. This increase was particularly noticeable among black men; small increase was also observed for white men and black women.

The increase in mortality noticed in 1969-1975 as compared to the 1950-1969 experience was not uniform. It occurred in a minority of the 21 counties for each of the four sex-ethnic groups studied (Figure 1).

These changes in New Jersey were not affected by age composition when compared to the rest of the nation since the data were age adjusted to the same 1960 U.S. age population distribution used by Mason and McKay for both time periods.¹ The increasing mortality trend between the two time periods, particularly for black men, suggests real change rather than random fluctuation.

Migration patterns of the population could be contributing to the observed increase in counties along the Atlantic Ocean and the decline in the northeast section. The precise magnitude of this migration effect remains undefined. Furthermore, these cancer trends may reflect a substantial change in life style and presence of and control of environmental carcinogens, since the major increases were found in rural and semi-urban counties, with a decline or no change (in most instances) in the previously industrialized northeast counties.

This study shows the upward trend of cancer mortality in most ethnic and sex groups compared to Mason and McKay

data. Furthermore, average annual age standardized overall New Jersey cancer mortality for years 1969-1975 was higher for white men and women and black women compared to the SEER^a population (Table 2) for the years 1973-1976 indicating increased risk of cancer death among New Jersey residents.^{4,5} Black men of New Jersey had rates similar to the SEER^a populations.

Mortality is not a true indicator of cancer risk, though incidence is. The New Jersey statewide tumor registry is only a year old and little cancer incidence or secular trend information can be expected as yet. A study of both incidence and mortality rates in Newark for 1970-1974 (the high-density, industrially polluted, largest city in New Jersey)⁶ showed that the overall cancer burden of this city was not due to increased incidence—though some cite specific rates higher than the Third National Cancer Survey⁷ and Surveillance, Epidemiology and End Result populations.^{4,5}

CONCLUSION

It seems clear that this and previous studies on cancer mortality in New Jersey offer only a partial picture of the cancer problem which will be better defined only by incidence studies.

REFERENCES

1. Mason TJ and McKay FW: U.S. cancer mortality by county: 1950-1969. DHEW Publication No. (NIH) 74-615. Washington USGPO, 1974.
2. Louria DB, Thind IS, Najem GR, Lavenhar MA, Hamm R, and Lemming E: Cancer in New Jersey: An overview. *J Med Soc NJ* 73:749-752, 1976.
3. Bureau of Census. U.S. Census of Population, 1960 Characteristics of the Population. Washington USGPO, 1963, Vol. 1.
4. Bailar JC and Ederer R: Significance factors for the Ratio of a Poisson variable to its expectations. *Biometrics* 20:639-643, 1964.
5. Young JL, Ardyce AJ, Pollack ES: Surveillance, epidemiology and results program. Cancer incidence and mortality in the United States 1973-1976. U.S. Department of HEW, Public Health Service, NIH, DHEW Publication No. (NIH) 78-1837.
6. Thind IS, Carnes R, Najem GR, Guartello G, Feurman M, Louria DB: Cancer incidence and mortality in Newark, N.J., 1970-1974—A national comparison. *Cancer* 47:1047-1053, 1981.
7. Cutler SJ, Young JL: Third national cancer survey—incidence date 1969-1971. U.S. Department HEW Public Health Service, NIH, DHEW Publication No. (NIH) 75-787.

Table 2

Average Annual Age Adjusted (1970 U.S. Standard)
Cancer Mortality Rates per 100,000 Population
in New Jersey and SEER^a Populations

Race and Sex Group	New Jersey	SEER
White male	231.6	209.6
White female	155.6	136.1
Black male	289.0	288.0
Black female	175.0	159.4

For calculations of age adjusted rates, the average annual age specific mortality rates for years 1969-1975 for New Jersey and 1973-76 for SEER^a populations were used.

^aSurveillance, epidemiology, end results

CASE REPORTS

An Unusual Case of *Hemophilus Influenzae* Infection*

MARTHA SITTELMAN, M.D. and BENJAMIN JOSEPHSON, M.D., Summit

An unusual case of bilateral symmetrical abscess formation in the feet of a three-year-old female due to *Hemophilus Influenzae* infection is described. Many symptoms presented and many differential diagnoses were considered before the definitive diagnosis evolved.

The wide spectrum of any disease is a constant source of challenge and fascination to the clinician. A case report of an uncommon manifestation of a fairly common childhood pathogen is presented.

CASE REPORT

The patient was a three-year-old female who had been in excellent health until three weeks before the present illness. At that time, she had a respiratory infection which was treated with erythromycin for four days and which completely resolved. Antibiotics had been discontinued ten days prior to the onset of the present illness.

On the first day of this illness, the patient complained of low back pain, but was otherwise well. The following day, she complained more vigorously of the back pain, had a fever of 38.9°C (102°F) and she vomited twice. She was examined and found to have tense and tender paraspinal lumbar musculature. A complete blood count, SMA₆ and urinalysis were normal at this time. On the third day, there was no emesis but the fever and back pain continued. She could move her legs and walk well even though the lumbar spasm persisted. Spinal and abdominal radiographs were normal.

By the fourth day, the back pain had diminished; however, she began to complain of bilateral foot pain and refused to walk. Her temperature rose to 40°C (104°F) and she was admitted to the hospital. On examination, her feet appeared normal but were exquisitely sensitive to touch. She also

displayed mild but diffuse bilateral tenderness of leg and lumbar musculature. She could not dorsiflex her feet or move her toes; when placed on her feet, she would walk with great reluctance and only on her toes. Strength in all muscle groups and all reflexes were normal.

Initial laboratory studies were: WBC 8,700 with 60% polys, 12% lymphocytes, 6% monocytes and 22% band form polys; sed rate: 63; cerebrospinal fluid: WBC 0, RBC 6, total protein 2mgm/dl, glucose 71mgm/dl and negative gram stain; throat culture: normal flora; culture of cerebral spinal fluid (CSF), urine and blood: no growth; radiographs on both feet were normal.

On the fifth day, the fever continued in the 40° to 40.6°C (104° to 105°F) range, the back pain diminished but the foot pain continued. Her examination was otherwise still normal.

On the morning of the sixth day, a faint erythematous swelling on the dorsal aspect of both feet appeared. A transient diffuse, erythematous macular rash appeared on the trunk, then disappeared over a few hours. The fever continued to spike to 40.6°C (105°F).

Further laboratory studies showed: bone scan: normal for age with increased symmetric uptake, both feet; CBC: WBC 21, 200 (P66, L4, M7, stabs 23) with toxic granulations; sed

*From the Overlook Hospital (Summit) Family Practice Residency Program where Dr. Josephson is Associate Director and Dr. Stitelman is a third-year resident in family practice. Correspondence may be directed to Dr. Josephson at 193 Morris Avenue, Summit, NJ 07901.

"Hemophilus Influenzae is a relatively common pathogen of children under the age of five."

"... it is important to include specific culture techniques and therapy for this organism in the evaluation of any suspected infection."

rate: 47; latex fixation, antinuclear antibody (ANA), febrile agglutinins: negative.

By the seventh day, the swelling of both feet increased especially on the dorso-lateral aspects. The areas then were incised and drained of a large quantity of gray purulent matter containing many gram-negative rods. Ampicillin and gentamicin were started intravenously before culture return. Within 72 hours after initiation of antibiotics and drainage, the patient defervesced. The swelling of both feet rapidly resolved. Cultures subsequently grew *Hemophilus Influenzae* and since this was sensitive to ampicillin, the drug was given intravenously for ten days and orally for another three weeks. Routine serotyping is not done on this organism in this community hospital. The patient gradually began weight bearing and walking.

DISCUSSION

Hemophilus Influenzae is a relatively common pathogen of children under the age of five. A review of the spectrum of infections by Dajani *et al*¹ notes that cellulitis, septic arthritis and osteomyelitis are uncommon manifestations of disease caused by this organism. In their 292 cases of *Hemophilus Influenzae* infections reported, only four cases of abscesses were mentioned. In three other reports demonstrating the rarity of abscesses, only six cases were reported.^{2,4} Two of these abscesses occurred at sites of previous penicillin injec-

tions;³ no source of trauma was obvious for the other four. Septicemia was documented in one case² and presumed in the others. None of the cases showed the striking bilateral symmetry of our case.

CONCLUSION

Few generalizations can be made based on one unusual case of a specific organism and disease entity it causes; however, with the prevalence of *Hemophilus Influenzae* infections in younger children, it is important to include specific culture techniques and therapy for this organism in the evaluation of any suspected infection.

REFERENCES

1. Dajani AS, Asman BI, Thirumoorthi MC: Systemic *Haemophilus Influenzae* disease: An overview. *J Pediatr* 94:355-364, 1979.
2. Feigin RD, Shackelford PG, Keeney R: *Hemophilus Influenzae* abscess associated with septicemia. *Am J Dis Child* 121:534-535, (June) 1971.
3. Sanders DY, Russell DA, Gillam CF: Isolation of *Hemophilus* species from abscesses in two children. *Pediatr* 42:683-684, 1968.
4. Rogers KB, Zimmerman K, Foster WP: Isolation and identification of *Hemophilus* species from unusual lesions in children. *J Clin Pathol* 13: 519-522, 1960.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out by themselves for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physicians Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

Bile Peritonitis After Routine T-Tube Removal*

NORMAN ROSENBERG, M.D., STEPHEN F. KONIGSBERG, M.D. and
NORMAN M. FINKELSTEIN, M.D., New Brunswick

Two patients are reported in whom a T-tube was removed on the tenth and eleventh postoperative days respectively, with the subsequent development of bile peritonitis requiring reoperation in each case. The factors involved in the etiology of this rare complication are discussed, and measures for its prevention enumerated.

Cholecystectomy is probably the most common major intra-abdominal procedure in the United States, and in various reported series common bile duct exploration and T-tube drainage was carried out in five to 25 percent of such procedures. Current practice involves performing a cholangiogram via the T-tube after the seventh or eighth postoperative day, followed by a period of progressive clamping of the tube prior to its removal.² In the 40-year experience of the senior author, no previous catastrophic complications have followed this regime. Recently, and in the course of only one year, we have seen two cases of severe bile peritonitis following removal of a T-tube leading us to revise our management of this device.

CASE ONE

A 53-year-old female was seen initially because of severe regional ileitis with ileo-ileal fistula, plus incidental cholelithiasis. The patient first was treated with steroids with no significant relief of symptoms. She then was subjected to resection of the terminal ileum and cecum with end-to-end ileo-ascending colostomy. At surgery, the gallbladder was found to contain stones and was removed. Since the common bile duct appeared dilated, choledochotomy was performed. No stones were found, and the duct was closed over a number 14 T-tube, using interrupted 3-0 chromic catgut. An operative cholangiogram was normal as was a T-tube cholangiogram performed on the ninth postoperative day, after which the T-tube was clamped and removed on the tenth postoperative day. The patient immediately com-

plained of abdominal pain, and her condition gradually deteriorated over the ensuing 48 hours. On the 13th postoperative day, she was reexplored and was found to have extensive bile peritonitis. A T-tube was reinserted and the right upper abdomen was drained. During the dissection in the right upper quadrant, a tiny sealed-off leak at the ileo-colic anastomosis was uncovered and reinforced with one suture and an omental patch. The T-tube tract, as observed at this operation, was poorly formed, thin-walled and interrupted in places. The postoperative course was complicated by the development of two fistulae thought to be related to the ileo-colic anastomosis. With intravenous hyperalimentation, she made a satisfactory recovery and left the hospital to return for successful repair of the fistulae at a later date.

CASE TWO

A 65-year-old male underwent cholecystectomy and common bile duct exploration for cholelithiasis associated with hyperbilirubinemia and transient elevation of both amylase and liver enzymes. The preoperative bilirubin was 4.7 of

*From the Department of Surgery, Middlesex General Hospital, New Brunswick, New Jersey, and Rutgers Medical School, CMDNJ, Piscataway, NJ. Dr. Rosenberg is Director, Department of Surgery, Middlesex General Hospital and Clinical Professor of Surgery, Rutgers Medical School, CMDNJ. Drs. Konigsberg and Finkelstein are Assistant Clinical Professors of Surgery, Rutgers Medical School, CMDNJ. Correspondence may be directed to Dr. Rosenberg at Middlesex General Hospital, 180 Somerset St., New Brunswick, NJ 08903.

which 2.7 was direct, the alkaline phosphatase was 200, SGOT was 390, and amylase was 256, falling to 73 on the third day of hospitalization. At exploration the bile duct was found to be free of stones and this was confirmed by both operative and T-tube cholangiography, the latter being performed on the eighth postoperative day. Following a period of progressive clamping, which was well tolerated, the T-tube was removed on the eleventh postoperative day. The patient experienced immediate severe abdominal pain which became progressively worse over an eight-hour period. Laparotomy then was performed and severe bile peritonitis was found. The opening in the common bile duct could not be located at surgery due to the severe inflammatory reaction, but the right upper quadrant was drained thoroughly with sump and Penrose drains. The bile peritonitis subsided but his postoperative course was complicated by minor upper gastrointestinal hemorrhage and pneumonitis, which responded to conservative treatment. This patient subsequently was found to have a carcinoma of the right lung, not apparent on his preoperative chest film.

DISCUSSION

In a recent paper Domellof *et al.*¹ were able to demonstrate leakage from the T-tube tract in 25 of 51 patients, by injecting radio-opaque contrast material (diatrizoate 45 percent) during removal of the tube. In eleven patients this leakage was limited to the vicinity of the tract, but in eight instances intra-abdominal leakage was noted. No patient required laparotomy. Their findings led them to state that "when the T-tube is removed within 5 to 13 days postoperatively, the T-tube tract is ruptured in every other case." They felt that pulling up a double thickness of tube (made up of the two limbs of the "T") may be partially responsible, suggesting appropriate tube modifications to avoid this.

Since encountering this problem, and since becoming aware of the above study, we have modified our management of the T-tube. Firstly, half the circumference of the horizontal limb of the "T" is trimmed away, so that as these limbs are folded together during withdrawal, the equivalent of only

one thickness of tubing is pulled through the tract, instead of two. Secondly, we have become more conservative as to the timing of T-tube removal, waiting at least 14 days, and preferably removing the tube during a postoperative office visit.

Other debilitating illness may have been a factor leading to poor tract formation in these two patients. In Case One, the patient had chronic ileitis and was on steroid therapy, factors associated by Tenenbaum *et al.* with the development of postoperative pneumoperitoneum via unsealed drainage tracts in four similar patients reported by them.³ Case Two, while in apparent good health at the time of surgery, was harboring an unrecognized pulmonary carcinoma.

SUMMARY

Current postoperative management of patients with T-tubes in their common bile ducts involves the performance of a cholangiogram via the tube, usually between the seventh and tenth postoperative days, followed by progressive clamping of the tube prior to its removal. Two patients are presented in whom these procedures were followed, and in whom the T-tube was removed on the tenth and eleventh postoperative days respectively. Both patients complained of immediate pain, which became diffuse and associated with a steady deterioration of their condition. Laparotomy disclosed extensive bile peritonitis in both, and appropriate drainage was instituted with recovery. Pertinent literature is reviewed and measures suggested to prevent this rare complication.

BIBLIOGRAPHY

1. Domellof, L., Rydh A., and Truedson H: Leakage from T-tube tracts as determined by contrast radiology. *Brit J Surg* 64:862-863, 1977.
2. Glenn F: The management of common duct drainage. *Surg Gynec and Obstet* 105:238-244, 1957.
3. Tenenbaum M, Bauer JJ, Gelernt IM, Kreel I, and Aufses AH Jr: Postoperative pneumoperitoneum: An unusual etiology. *Ann Surg* 188:769-772, 1978.

This publication is available in microform.



University Microfilms International

Please send additional information for _____
(name of publication)

Name _____

Institution _____

Street _____

City _____

State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

SPECIAL ARTICLE

The Carrier Foundation

ROBERT S. GARBER, M.D., Belle Mead*

The transition from a "sanatorium" in 1910 to be a modern multifaceted mental health care facility which combines treatment, research and professional education in 1981 is described.

For many in New Jersey's medical community, the Carrier Foundation, formerly known as the Carrier Clinic, needs no introduction. Over the years, psychiatrists and other physicians in many parts of the state have referred patients to this facility when the need has arisen for a specialized, private psychiatric hospital. However, an up-to-date account of the patient services and related programs, together with some historical background, should be of interest.

Carrier's original progenitor, the Belle Mead Sanatorium, was founded in 1910, a private facility for patients with chronic mental disorders. Treatment measures available to psychiatrists were, at that time, primitive as compared to the state of the art today. Yet, private institutions were able to achieve commendable results through what later became known as "moral treatment," consisting mainly of individualized attention and humane care. By contrast, the public institutions of that day, described dramatically by Clifford Beers in his historic biography, *The Mind that Found Itself*, were unable, because of enormous populations and inadequate staffing, to provide more than indifferent custodial care, at best.

The ensuing decades witnessed significant changes in the management of mental illness, attributable to improvements in the physical conditions of the hospitals, advances in professional training, increases in professional personnel, introduction of convulsive therapies (insulin, metrazol and

electroshock), and, in the private hospitals, at least, individual and group psychotherapy. Yet, with all these advances, most patients admitted to public psychiatric hospitals could expect to remain there for years, some even for life.

Each medical specialty can point to an innovation which revolutionized the management of a particular illness or group of illnesses. For psychiatry, the innovation was the introduction of psychotropic drugs in the middle 1950's. With these agents it became possible to treat and discharge most hospitalized patients in a matter of months, even weeks. It also became clear, correlatively, that the goal of "total cure" was inappropriate in the treatment of the psychoses. Restoration to normal or near-normal functioning through treatment and well-planned after-care services in the community was much more realistic. Within the rationale of this redefinition, recurrence was no longer synonymous with failure; readmission and renewal of treatment were to be expected in a fair proportion of cases.

It was during this period that the Belle Mead Sanatorium became the Carrier Clinic, the name deriving from that of its new owner, Dr. Russel N. Carrier. Considerably more than the name was changed. From a facility devoted, typically, to long-term care of chronic patients, there emerged the framework of a modern psychiatric hospital for short-term, intensive treatment. The "Carrier Concept," our guiding

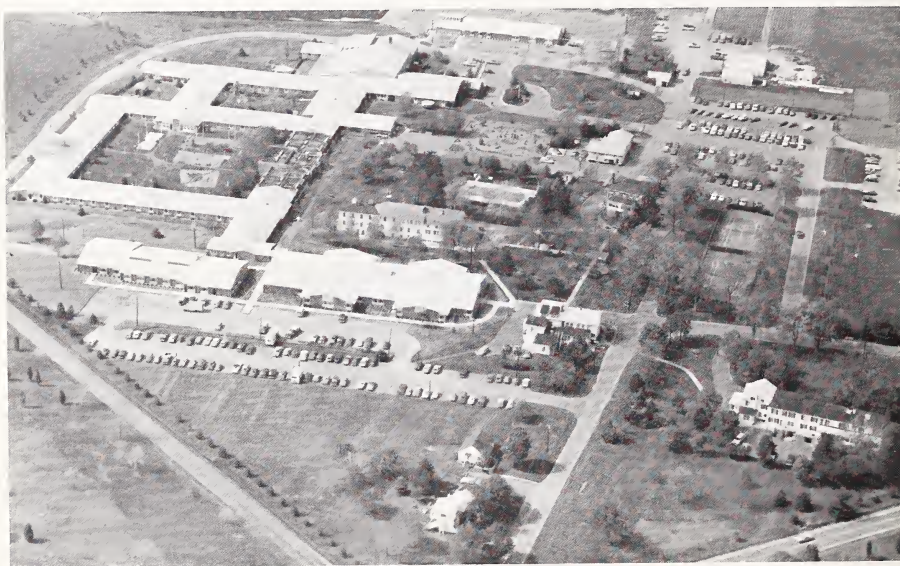
*Dr. Garber is President of the Foundation and may be addressed there—Belle Mead, NJ 08502.

principle, also was born then, namely: "The maximum in-hospital treatment, the minimum in-hospital atmosphere."

In retrospect, one can see that for 1955, the first year of the Carrier Clinic's existence, its goals were far ahead of its time and of its physical limitations as well. The facility consisted then of several frame buildings in a pleasant farmland setting. The bed capacity was 89 and the staff consisted of three psychiatrists and a few nurses and aides. The annual admission was approximately 250. But, the vision and creativity of Dr. Carrier's staff set into motion the process which ultimately brought about a remarkable transformation.

THE PRESENT FACILITY

Today, the Carrier Foundation has 245 beds with an annual admission of 2,800, a staff of 27 fulltime psychiatrists, more than 100 nurses, 15 social workers, psychologists, counselors, and adjunctive therapy specialists. In addition there is a consultant staff of more than 130 physicians, surgeons and other professionals covering every pertinent specialty.



Carrier Foundation—Belle Mead, New Jersey

A wide range of disorders are treated at Carrier: anxiety states, phobias, obsessive-compulsive behavior, depression, schizophrenia, manic-depressive illness, senile-dementia and related geriatric disorders, alcoholism, drug addiction and others. Special services include an Addiction Recovery Unit, a Geriatric Unit and a biofeedback center for such disorders as headaches, hypertension, asthma and chronic pain. There are special treatment programs for anorexia nervosa and for emotionally disturbed adolescents. Currently under construction, and soon to be in service, is a 24-bed alcohol recovery unit for patients without significant psychiatric or medical problems.

The goal at Carrier is to return the patient in the shortest possible time to home, community and occupation. The average stay has remained consistently at 28 to 30 days during the past several years. It is our belief that the physical

surroundings and the quality of daily life have as important a role in the recovery of the psychiatric patient as do the treatment procedures themselves. This principle is manifest in the contemporary architecture of the buildings which house the patients' treatment services and living quarters; the attractive decoration and furnishings of the patients' rooms, dining room, lounges, chapel, craft shops and gymnasium; the lawns, gardens, swimming pool, tennis courts and other recreational facilities on the exterior.

Carrier patients come from all walks of life. The expenses of most are paid, almost in their entirety, by some form of health insurance, including Medicare and Medicaid. Sixty percent of the patients are referred by psychiatrists and other physicians; thirty percent by community mental health services and professionals, schools and courts. Five percent are self-referred.

Carrier's patient-care program is balanced by extensive programs of research, education and training.

RESEARCH

The goal of the fulltime Research Division is to conduct

clinically relevant basic and applied research on human behavior and the causes and treatment of psychopathology and mental disorders. Several studies are in progress and nearing completion, including double-blind evaluations of hemoperfusion (in treating chronic schizophrenia), anafranil (obsessive compulsive disorders), and dexamethasone (memory impairment following electroconvulsive therapy (ECT)). A followup of 225 patients, interviewed each year for four years, is providing exciting new information on the recovery from alcohol addiction. Some of these patients are being followed additionally (in collaboration with Rockefeller University) to evaluate biochemical changes in recovered alcoholics. Studies of a new structured interview evaluating addiction severity (with the University of Pennsylvania) and the biochemical bases of alcohol-induced hypertension are currently in progress. Hypnosis is being investigated both as

a paradigm for certain aspects of psychopathology (e.g., memory disorders) and as a treatment adjunct. The importance of sleep disruptions in understanding and treating psychiatric disorders is being investigated.

PROFESSIONAL EDUCATION

Innovative education has been a hallmark at Carrier for almost a quarter century.

Responding to an urgent need, the Carrier Clinic initiated a series of varied psychiatric programs for physicians in 1957. Starting as a course of lectures, the format was changed in 1966 to a biennial symposium and in 1970 to an annual symposium. The range of topics has been broad: violence and aggression, human sexuality and treatment of sexual disorders, adolescents and drugs, alcoholism, depression, psychiatric drugs in medical practice, the medico-legal crisis, and the expanding dimensions of consciousness. In 1978, 1979, and 1980, the following symposia were held: "Aging: Ourselves Tomorrow," "The Child at Risk," and "Eating and Weight Disorders." These educational experiences have become annual events of note, owing to the timeliness of the topics and to the caliber of the faculty.

Distinguished faculty members from various national schools and every clinical discipline come to lecture at weekly sessions in continuing education and monthly colloquia. Soon to be added to Carrier's expanding calendar of educational activities are new workshops, "mini-symposia," and clinical courses, many to be held off-campus.

Through affiliation with Rutgers Medical School and Hahnemann Medical College, Carrier provides training for forty third-year medical students annually. In addition there are rotating residencies in family practice from the Kennedy Medical Center. Eight nursing schools affiliate to provide clinical experience for more than 600 student nurses. Graduate students from social work, psychology and adjunctive therapy degree programs also are trained regularly at Carrier.

SUMMARY

Quality education continues to be a high priority at the Carrier Foundation. We look to a future in which Carrier will continue to improve and grow, drawing on and contributing to advances in treatment, research, education and training.

TRS-80 (TM) and the Surgeon

DONALD ROTHMAN, M.D., Red Bank*

The proliferation of computer hardware has been astounding. The energies spent to develop uses (software) is nearly incomprehensible. The pervasiveness of this combination of machine and man's ideas has amounted to a true computer revolution.¹ In case you haven't noticed, applications of computers in medicine already have had impact. Recent conferences have occupied a full week of high-level medical computing exchanges.²

If someone had told me ten years ago that I would be able to store the surgical data of a career at my fingertips for several thousand dollars, I would have seized the opportunity. At the present time the stimulus for office computerization is managerial and financial; and, to these ends the current systems are well suited. Analysts will set up programs to bill, write insurance forms, schedule and recall patients and perform similar functions. These applications can turn large offices with many physicians and employees and large patient turnover into smoothly functioning units. This, of course, requires significant investment in computer machinery, accessories and software (programs) as well as personnel training and maintenance.

In my own office, more modestly, I utilize a TRS-80 Model I computer using the Profile (TM) data processing system to tabulate basic information in various fields. This includes all my patients with carcinoma of the colon, breast and thyroid; fine-needle aspiration biopsies; vascular cases; interesting cases by topic; hyperalimentation data and records of continuing medical education. One can itemize with a simple format those bits of information which one wishes to recall (See Figures 1 and 2). Figure one shows how one can store basic information on colon carcinoma with enough flexibility to add more information at a later date.

The Profile system sorts rapidly by alphabet, recalls files for correction, updates (edits) and prints hard copies (permanent records). Mainly, this allows the surgeon rapidly to recall and itemize classes of patients for study. I have found this permits me to compare and evaluate age groupings,

demographics, stages of disease and followup. These reminders indicate missing data, such as CEA values and hormone receptor studies of tissue. One is driven to be more precise in determining and recording the size of lesions, the status of lymph nodes and the like. In followup of vascular surgery review of graft patency allows comparative study by the surgeon to assess his work.

By regularly entering such information in this manner, one can get an overview of the experience of a career by computer technology that would be too burdensome by hand methods and, therefore, never would be done. Seriously consider it.

```
NAME:.....
ADD:.....
AGE:.. MD:..... DAY:.././.. PH:..-....
SYMPT:..... CEA:.. SCOPE:.....
BE:.....
SURG:.....
PATH:..... LN:....
T:.. N:.. M:.. STAGE:.. DUKES:..
RAD:.... CHEMO:....
DATA:.....
```

Figure 1—A format for study of colon carcinoma.

```
CAT: ...
SPONSOR: .....
CITY: ..... STATE: .....
SUBJECT: .....
DATES: .....
HOURS: ...

1. ACCRED 60-150 2. NON-ACCRED 45 3. MED TEACH: 45
4. PUBLISH 4X10 5. A.SELF 22 B.CONSULT 22 C. LIME
REVIEW 22 D. SELF ASSMNT 22 TOTAL 45 6. OTHER 45
```

Figure 2—A format to list continued medical education by category with a reminder as to the kinds of categories.

REFERENCES

1. Evans Christopher: *The Micro Millennium*. New York, Viking Press, 1979.
2. Fourth Annual Symposium on Computer Applications in Medical Care. George Washington University Medical Center, Nov. 2-5, 1980.

*Dr. Rothman is a member of the surgical staff at Riverview Hospital, Red Bank. He may be addressed at Brigadoon Professional Building, State Highway 35, Red Bank, N.J. 07701.

The Conquest of Yellow Fever: The Rockefeller Foundation*

JOHN Z. BOWERS, M.D. and EDITH E. KING, New York

The Rockefeller Foundation's yellow fever program lasted four decades and embraced most tropical countries in the western world. Control of human yellow fever was achieved through mosquito eradication, identification of the causative agent as a filterable virus, and development of a vaccine.

Yellow fever ranks as the most dramatic pestilence in medical history with a high frequency in tropical and semi-tropical countries of the western world, especially West Africa and South America. We all have read of the fierce outbreaks in Philadelphia in the 18th century and of the highly debatable work of that city's leading physician, Benjamin Rush, in purging victims of the disease. As the northern seaports improved their sanitary programs, yellow fever retreated to the southern port cities, primarily New Orleans.

IN THE BEGINNING

A pivotal series of events in yellow fever history began in 1898 with the war between the United States and the deteriorating Spanish Empire. American soldiers invaded Cuba and within a short period a number developed yellow fever. Surgeon-General George Sternberg sent a commission under Walter Reed to investigate the problem and, based on studies by earlier pioneers led by Carlos Finlay, the Reed Commission indicted the *Stegomyia* mosquito as the vector of the disease. The narrative of yellow fever reveals a shockingly high death rate among physicians who volunteered to fight the disease. Jesse Lazear, a researcher and teacher at Johns Hopkins, who supervised the commission's mosquito program, contracted the disease in a fatal form while investigating *Stegomyia* on the yellow fever ward at the military hospital. James Carroll, Walter Reed's deputy,

recovered from an attack in Havana but was left with permanent cardiac damage which resulted in his demise ten years later.

NEW JERSEY'S CLARA MAASS

Clara Louise Maass, Belleville, New Jersey is the unsung heroine of the Havana campaign. After nurse training at the German Hospital in Newark, she enrolled as a military contract nurse and was assigned to the Philippines where she developed dengue and was invalidated home. After her recovery, Clara Maass moved under orders to work with William Gorgas who was leading the Army's Havana campaign against yellow fever. She heroically nursed more than a hundred cases of yellow fever before dying from the disease in Havana in 1901. Today we pay homage to her through the Clara Maass Memorial Hospital in Belleville, New Jersey.

A WORLDWIDE CAMPAIGN

After its charter was approved in the spring of 1913, the Rockefeller Foundation launched a world-wide campaign against hookworm disease which its antecedent organization, the Rockefeller Sanitary Commission, had been attempting

*Read before the first meeting of the Medical History Society of New Jersey, October 8, 1980, Rutgers Medical School, Piscataway. Dr. Bowers and Miss King are serving as consultants to The Rockefeller Foundation while writing a history of its programs in health and natural sciences. They may be addressed at The Rockefeller Foundation, 1133 Avenue of the Americas, New York 10036.

to eradicate in the southern states since 1909. Wickliffe Rose, who was a devout Baptist, like Mr. Rockefeller, and a philosopher by training, visited hookworm programs in the Far East in 1914, the year that the Panama Canal opened. He was reminded by British medical officers of Sir Patrick Manson's strong expression of concern that the canal would open an avenue by which yellow fever would be disseminated across the Asian world where heretofore the disease had not existed. On his return to America, Rose consulted Gorgas who assured him that yellow fever readily could be eradicated from the western hemisphere. It was hoped that this would allay anxieties about the canal.

The concept on which the foundation's first attack was based concentrated on the eradication of the mosquitoes' "endemic centers." The first target selected, Guayaquil, Ecuador's leading seaport, was listed as a hotbed of yellow fever. Weil's disease, which was caused by *Leptospira icterohaemorrhagiae*, and closely resembled yellow fever in its clinical manifestations, was also endemic in the seaport. A 1918 Rockefeller commission led by faculty members from Northwestern Medical School in Chicago, eradicated breeding places for the *Stegomyia*, henceforth designated *Aedes aegypti*. Their procedures included oiling the water surfaces of all containers and introducing larvae and mosquito-devouring fish. House-to-house inspections assured the effectiveness of the control measures.

A development that was to lead to at least a decade of controversy began with the arrival at Guayaquil of the Japanese bacteriologist, Hideyo Noguchi, from the Rockefeller Institute. He immediately set about laboratory investigations on the causative agent and in a few weeks announced the identification of a new spirillum responsible for the disease, *Leptospira icteroides*. His announcement received general acceptance in medical-scientific centers and was supported by his teacher, Simon Flexner. But leaders in tropical medicine soon were questioning its validity, in part because the spirillum seemed identical with *Leptospira icterohaemorrhagiae* and Weil's disease was known to be prevalent in Guayaquil.

For centuries Brazil had been the cradle of yellow fever in the Western hemisphere; the highest incidence was in the northeastern region. A fierce epidemic that erupted in Rio de Janeiro in 1908 was controlled by Oswaldo Cruz whose name became immortal for his brilliant leadership in eradicating *Stegomyia*. In 1923 the Rockefeller Foundation launched a campaign against yellow fever in northeast Brazil, stretching from Salvador, Bahia to the Amazon Basin. As in Guayaquil, *Aedes aegypti* was the target and the weapons were larvae-devouring fish and oil placed in all water containers. Although success was achieved within one year, the disease continued to flare up. Questions persisted regarding the reliability of the endemic foci theory and a turning point came with an epidemic in Rio de Janeiro in 1928.

In that year, Fred Lowe Soper, who led the foundation's program, became deeply concerned over the inadequacy of existing methods of diagnosis. The specific liver changes described by Councilman were unreliable, for the natives abhorred postmortems and used physical violence to protect corpses. Soper turned to Elsmere R. Rickard, of the foundation staff in northeast Brazil, for assistance in partial autopsies with scissors and a scalpel. Such an approach did not satisfy Rickard, and he invented a viscerotome which penetrated the abdominal or chest wall, making only a small opening and withdrew a sliver of liver tissue for microscopic examination. The viscerotome consisted of a four-sided

trocar with sharp ends at the bottom, within which lay a flexible and movable steel blade which cut out the strip of tissue. Determination of the epidemiology of yellow fever became greatly improved by the availability of this instrument, and native reactions against violation of a corpse were allayed. Rio de Janeiro suffered another epidemic in 1929 but by that time the endemic foci theory had been abandoned.

Brazil was the heartland of yellow fever in the Americas and West Africa was the counterpart region in the east. Gorgas led the first foundation commission in 1920; he fell with a stroke in London and King George V came to his bedside to bestow a knighthood. Before Gorgas' body was returned to America, a funeral service with appropriate pomp and ceremony was held at St. Paul's Cathedral. The commission moved on to Africa and learned that yellow fever prevailed throughout the tropical belt, from the southern sands of the Sahara Desert to Angola at the southern border of the vast Belgian Congo. Eastward, the disease extended to the Anglo-Egyptian Sudan.

In 1925 the foundation opened a West Africa campaign with laboratory headquarters at Yaba, a suburb of Lagos, Nigeria's capital and major seaport. The scientific basis of yellow fever evolved from the highly productive research programs at Yaba, headed by Henry Beeuwkes, for which medical officers in the British laboratory at Accra, the Gold Coast, and the French at Dakar, the capital of French Equatorial Africa, contributed excellent cooperation.

Nineteen twenty-seven became the banner year beginning with the identification of *Macacus rhesus* monkeys as highly susceptible, with a disease pattern quite similar to that in man. Furthermore, the transfer of infection from monkey to monkey readily could be accomplished by allowing *Aedes aegypti* to feed on an infected animal. The usual incubation period was sixteen days or more. Adrian Stokes from Guy's Hospital, London, joined the commission and performed experiments which proved that the etiological agent was a filterable virus. Henceforth Noguchi's theory of *Leptospira icteroides* was discarded, a consideration which was fortified by the fact that it was not found in the blood or tissues of the many patients studied by the commission. Two strains of yellow fever virus were established, Asibi and French.

Tragically, Adrian Stokes died in Lagos on September 15, 1927, from the very disease that he was investigating, the first of four staff members to fall victim. When Noguchi learned of Stokes' death and that proof that his *Leptospira icteroides* was not the causative agent, he sailed to Africa in January 1928 to join the yellow fever forces. He established his research at the British Medical Research Institute on the campus of the Korlu Bu Hospital in Accra. The institute's director, W.A. Young, who was investigating the bacteriological and pathological aspects of yellow fever, placed all of the laboratory's facilities at Noguchi's disposal. During a visit to the Yaba laboratory, Noguchi became ill and died from yellow fever in Accra on May 21, 1928. W.A. Young performed the autopsy which verified the diagnosis and only nine days later he also died from yellow fever.

After he became director of the International Health Division in March 1923, Frederick Russell pressed for the addition of research to the exclusive emphasis that Wickliffe Rose had placed on field work. His primary goal was the creation of a laboratory in New York City at the Rockefeller Institute, but Simon Flexner was adamantly opposed on the grounds that he could not endanger his staff by exposure to yellow fever. After several years he finally capitulated and, in 1928, the Rockefeller Foundation Yellow Fever Laboratory

opened with Wilbur A. Sawyer as its first director. Because of the recent deaths of Stokes, Noguchi and Young, Sawyer decided that only medical men should be allowed to participate in research during the early stages. The Asibi and French strains of virus were established and a freeze-drying technique was developed by which the virus could be preserved with its disease-producing qualities intact for as long as six years.

A MOUSE-PROTECTION TEST

In 1930 Max Theiler at the Harvard School of Public Health developed a mouse-protection test by which mice were inoculated intracerebrally and the virus neutralized by intraperitoneal injection of immune serum. Sawyer applied this as the mouse-protection test for determining immunity to yellow fever in important world-wide studies on the occurrence of the disease.

Meanwhile, investigators at the laboratory at Dakar used mouse passage to modify the French strain of virus for vaccination of humans. It afforded excellent protection but use became limited due to the high rate of serious reactions.

YELLOW FEVER VACCINE

Theiler moved from Boston to the New York laboratory where, in 1936, he collaborated with Hugh Smith and Wilbur Sawyer to develop an effective vaccine against yellow fever. The Asibi strain of virus was cultivated in chick embryos with 17 passages after which both the viscerotropic and neurotropic virulence were markedly reduced. Wide-scale vaccination with 17D vaccine began in 1937 and resulted in almost complete eradication of human yellow fever. The sole misfortune resulted from the use of human sera contaminated with hepatitis virus in the vaccine prepared for multiple vaccinations. As a result a number of deaths occurred in American servicemen in the early months of World War II.

JUNGLE YELLOW FEVER

Investigations in Brazil and Colombia in the 1930s defined outbreaks of yellow fever in persons exposed to jungle areas, but *Aedes aegypti* could not be identified as the vector. This led to the discovery of jungle yellow fever which was endemic in monkeys and was transmitted by *Haemagogus spegazzinii* mosquitoes. A similar form of the disease was found to exist in East Africa through studies emanating from the foundation's laboratory at Entebbe, Uganda.

The jungle form of yellow fever continues to exist today. In the 1950s there were outbreaks of human infection in individuals who had not been vaccinated. With the rigid controls now applying to the use of insecticides, mosquitoes as disease vectors have returned to the battle front. The recrudescence of drug-resistant malaria carried by insect-

icide-resistant mosquitoes which multiply on irrigation schemes, poses the most urgent problem. In 1979, there were an estimated 100,000,000 cases of malaria in Africa with 1,000,000 deaths.

The Rockefeller Foundation's striking success in the eradication of human yellow fever ranks as its finest achievement in the conquest of disease.

SUMMARY

Yellow fever ranks as the most dramatic pestilence in medical history in tropical countries of the western world. Important developments began in 1898 when American soldiers fighting in Cuba contracted yellow fever. A commission under Walter Reed proved the *Stegomyia* mosquito (later called *Aedes aegypti*) to be the vector. In 1916 The Rockefeller Foundation launched a program in Guayaquil, Ecuador, based on eradication of the mosquitoes' "endemic centers," with emphasis on oiling surfaces of water containers and introducing larvae and mosquito-eating fish. Despite success achieved with these methods, the disease continued to flare up and questions persisted regarding the endemic foci theory.

Existing methods of diagnosis were inadequate until invention of the viscerotome for collection of liver tissue for microscopic examination. That instrument greatly improved the determination of the epidemiology of yellow fever.

In 1920 the Foundation sent a commission to West Africa; it found that yellow fever was spread throughout the tropical belt. A research laboratory was opened at Yaba in Nigeria, where in 1927 the *Macacus rhesus* monkey was found to be susceptible to yellow fever, thus providing an experimental animal. Noguchi's theory, first announced in Guayaquil, that a spirillum, *Leptospira icteroides*, was responsible for the disease, was discarded when Adrian Stokes, a member of the West Africa Commission, proved that the agent was a filterable virus.

The Foundation's yellow fever laboratory at The Rockefeller Institute in New York City was opened in 1928 under the direction of Dr. Wilbur A. Sawyer. In the next decade Dr. Sawyer applied a mouse-protection test, developed by Dr. Max Theiler at the Harvard School of Public Health, to determine immunity to yellow fever on a world-wide basis. In 1936 Dr. Theiler moved to the New York laboratory where, in collaboration with Drs. Hugh H. Smith and Wilbur Sawyer, he developed an effective vaccine against the disease. In 1951 Theiler was awarded the Nobel Prize in Medicine for this accomplishment. Wide-scale vaccination was begun in 1937 and has resulted in almost complete eradication of human yellow fever. Jungle yellow fever, endemic in monkeys and transmitted by *Haemagogus spegazzinii* mosquitoes, was discovered in the 1930s. This form of the disease exists today.

Selected Abstracts with Comments

Sachis PN et al: The vagus nerve and sudden infant death syndrome (SIDS): A morphometric study. *J Pediatr* 98:278, 1981

The authors have carried out complex morphometric studies on the cervical vagus nerve in 22 infants who had died of SIDS (study group) and 14 infants of comparable ages who had died of other causes (control group). There was a statistically significant difference in the counts of small (less than 2 microns in diameter) myelinated vagus fibers (MVF) between the two groups, the counts being strikingly less in SIDS victims. This indicates abnormal or delayed development of vagus nerve in SIDS infants. The small MVF normally innervate the "irritant" receptors which respond to particulate matter by cough and rapid shallow breathing. The reduction in the number of small MVF in SIDS infants may result in suppression of this response. Thus this lesion may contribute to the cause of SIDS. On the other hand, the reduction in the number of small MVF in the vagus nerve may be the result of chronic hypoxemia in SIDS infants. Thus it is not possible to determine whether the vagus nerve abnormality demonstrated in this study is the cause or effect of SIDS. However, this study adds one more piece of evidence that "sudden infant death" is not sudden—it is the terminal episode in a long pathologic process.

Comment: The etiopathogenesis of SIDS is not yet clear. The following hypothesis seems to be getting wider acceptance. The SIDS infants are vulnerable to develop apneic spells. The apnea may be idiopathic, occurring during REM sleep or may be related to upper airway obstruction. The protracted apneic spells result in chronic hypoxia. The following "tissue markers" of chronic hypoxia have been demonstrated by carrying out detailed morphometric studies on autopsy material in SIDS: increased medial muscle mass in walls of small pulmonary arteries, increased weight of right ventricle of heart, increased retention of brown fat, increased hepatic erythropoiesis, and so on. The prolonged hypoxic process ends in the terminal episode which we call sudden infant death syndrome. The findings of Sachis *et al.* can be interpreted as another "tissue marker" of chronic hypoxia. Their findings thus further strengthen the hypothesis mentioned above. (V.V. Joshi, M.D., Ph.D.)

Haworth JC et al: Fetal growth retardation in cigarette smoking mothers is not due to decreased maternal food intake. *Am J Obstet Gynecol* 137:719, 1980

To determine whether the fetal growth-retarding effect of maternal cigarette smoking could be due to a lower dietary intake in smokers than in non-smokers, the pediatric group of The Children's Hospital of Winnipeg assessed the energy and nutrient intake of 302 smoking and 234 non-smoking women toward the end of the last trimester of pregnancy. The smokers had significantly smaller infants, but pregnancy weight gain was not different. Daily dietary intake of the

smokers was not less than that of the non-smokers; in fact, for some nutrients it was significantly greater. Therefore, the authors concluded that fetal growth retardation due to smoking is not caused by the mother's diminished intake of food.

Comment: It was suggested previously that smoking might reduce the appetite of the mother (less weight gain during pregnancy) and thus result in undernutrition that might cause fetal growth retardation. However, the dietary intake of these mothers was never assessed directly. The present author apparently disputed the validity of the previous reports and claimed that it is unlikely that the harmful effect of smoking could be reversed by increasing the mother's dietary intake. The pathogenesis of fetal growth retardation in cigarette smoking is not fully known. The nicotine, carbon monoxide and cyanide content of cigarette smoke have been incriminated for the ill effects. It is difficult to persuade people to stop smoking. However, if all the hazards to the fetus are to be avoided, a real effort should be made to educate women on the dangers of smoking. (S. Sun, M.D.)

Peerless SA et al: Etiology of otitis media with effusion: Antihistamines—decongestants (AD). *Laryngoscope* 90:1, 1980

A detailed review of 50 patients with persistent middle ear effusion (MEE) revealed data which suggested that AD may be causative. A volunteer study revealed that mucociliary activity was decreased by AD. The recommendation was made not to use these drugs in patients susceptible to MEE.

Denhoff E: Current status of infant stimulation or enrichment programs for children with developmental disabilities. *Pediatr* 67:32, 1981. Ferry PC et al: On growing new neurons. *Pediatr* 67:38, 1981; Browder JA et al: The pediatricians' orientation to infant stimulation programs. *Pediatr* 67:42, 1981

These several articles and following letters present background research and current thinking about infant stimulation or early intervention (EI) programs for children with biologically based developmental disabilities. The child's eventual outcome depends on his neurological potential and the psychosocial environment which includes habilitation efforts. Although every child deserves therapeutic intervention to maximize his neurological potential, positive effects of EI programs are more likely to be seen in family adjust-

*Abstracted from the *Department of Pediatrics Newsletter, CMDNJ, New Jersey Medical School, Newark*—Vol 3, No. 3 (March) 1981. Selections are made by Richard H. Rapkin, M.D., Professor of Pediatrics and Medical Director of Children's Hospital, Newark, who is editor; Franklin C. Behrle, M.D., Professor and Chairman of Pediatrics; and Shyan C. Sun, M.D., Associate Professor of Pediatrics and Director, Department of Neonatology, Children's Hospital, Newark, who are coeditors. Comments are prepared by them and their associates.

ment than in striking developmental gains by the child. "Acceptance of the child into the family structure, the resolution of guilt feelings, and the establishment of realistic expectations" are agreed upon as important EI program objectives and should be offered to families.

It is clear from previous studies that biologically impaired children make more developmental progress in a family than in an institution and the costs are certainly less. The pediatrician may find himself overwhelmed with the burden of providing support and specific instructions to the family caring for a handicapped child. Close communication with an EI program can provide support for the professionals as well as the family.

Comment: In a recent *Study of Early Intervention Programs in New Jersey* prepared for the New Jersey Developmental Disabilities Council, parents were very positive about their active participation with their children in EI programs. They reported having a difficult time learning about the programs and desired closer communication between programs and the medical community. A list of current EI programs in New Jersey can be obtained by writing to Mrs. Georgette Dickman, Coordinator, Coalition of New Jersey Infant Program Administrators, The Child Center, 88 Hickory Avenue, Bergenfield, N.J. 07621. Despite the difficulties in documenting positive effects of EI programs, I have found them very helpful to families and refer children whenever possible. (D. Bryan, M.D.)

Moeschler JB et al: Use of CT scan in the medical evaluation of the mentally retarded child. *J Pediatr* 98:63, 1981

Twenty-three moderately to severely retarded children for whom no specific etiology could be assigned had CT scans without contrast; only one was abnormal, showing non-specific cerebral atrophy. Minor dysmorphic features were not helpful. The authors conclude that CT scans are not indicated for evaluation of mental retardation with no obvious cause.

Comment: This is interesting but inconclusive—the indications for CT scan in a developmental clinic are still uncertain. We have a patient in whom the suspected diagnosis of tuberous sclerosis was confirmed by CT scan but not on skull x-ray, a finding of substantial use in genetic counseling. (L. Bagdon, M.D.)

Levine MD et al: Developmental output failure: A study of low productivity in school-aged children. *Pediatr* 617:18, 1981

The authors describe a group of older children with mild, difficult to delineate, learning disorders producing poor school function in upper grade school and junior high. This group is often misunderstood and accused of emotional disorder, laziness, or undesirable personality traits. The possibility that such students are predisposed to social difficulties and delinquency is under study. There is a need to recognize and adjust to diverse learning styles and needs.

Comment: The description and comments are clear and consonant with what is known about mild learning disabilities; I hope the introduction of a new term, "developmental output failure," does not confuse the recognition that these are children with mild, difficult-to-detect learning disabilities. On the continuum of definite organic brain damage merging with minimal brain dysfunction—mild, learning disability—normal non-academically talented—normal—bright, there are no sharp boundaries. We all should encourage the authors' recommendation that "society acknowledge earlier in life the diversity of acceptable modes

of productivity . . ." (L. Bagdon, M.D.)

Roberts CJ et al: A study of the utilization of skull radiography in the nine accident and emergency units in the United Kingdom. *Lancet* 2:1234, 1980

This article is a combined study from England, Wales and Scotland investigating the usefulness of skull radiography in the management of patients with head injury. The question that was asked by the study is "how often is routine skull radiography of value and at what cost." A total of 5,850 patients in the nine centers were studied. The patients under 15 years of age composed 37 percent of the total. Age 16 to 64 comprised 50.6 percent and over age 64 there were 12.4 percent. There were 2,117 patients under age 15 and the incidence of linear fracture was 2.34 percent. This was almost identical in the other age groups. The incidence of depressed fracture was 0.14 percent. It is the opinion of the authors that a skull fracture may be a valuable predictor of posttraumatic intracranial hematoma and arachnoid. They further state that an intracranial hematoma or arachnoid is likely to occur in association with skull fracture in approximately 1 in 730 patients x-rayed. Also, the authors state that a skull x-ray is unlikely to contribute directly to the avoidance of death or secondary brain damage more than once in 1,460 patients x-rayed.

Comment: Although the authors appear to agree with the data presented in previous literature, there is one somewhat confusing aspect of this article. The authors stress the point that the presence of a skull fracture may be an aid in predicting the presence of an intracranial hematoma. This is at variance with previous literature which clearly demonstrates that the presence of a linear skull fracture in the absence of well-defined clinical abnormalities has practically no value in the clinical management of the patient. The authors fail to discuss the number of patients who had no demonstrable skull fracture but who, nevertheless, had significant intracranial pathology. I agree with **Harwood-Nash et al:** The significance of skull fractures in children: A study of patients. (*Radiology* 101:151, 1971) who state "The term 'fracture of the skull' is not synonymous with a significant intracranial injury; often it is only confirmatory evidence that a force was applied to the skull." (J. Marquis, M.D.)

Brazy JE et al: Isoxsuprine® in the perinatal period. II. Relationships between neonatal symptoms, drug exposure, and drug concentration at the time of birth. *J Pediatr* 98:146, 1981

Forty preterm infants with maternal Isoxsuprine® (ISX) exposure less than 24 hours before delivery and 40 matched controls were studied prospectively to determine the acute neonatal effects of maternal ISX group. The incidence of hypotension and hypocalcemia rose directly with the cord ISX concentration, reaching 89 percent and 100 percent respectively when the cord ISX level exceeded 10 ng/ml. (Duke University, Durham, N.C.)

Comment: Now that the FDA has approved the use of some beta adrenergic tocolytic agents, an increasing number of obstetricians may use them in the treatment of premature labor. Pediatricians must be aware of the possible complications of these agents in the newborn period. A routine inquiry of drugs used in the perinatal period will alert one to anticipate problems before they occur. Hypotension, hypocalcemia, hypoglycemia and ileus are life-threatening emergencies. (S. Sun, M.D.)

Summary of New Drugs Marketed in USA in 1980

This information is compiled by the Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Arnold and Marie Schwartz College of Pharmacy and Health Sciences, Long Island University.*

In response to numerous questions concerning new drugs marketed in 1980, the following information is provided.

Amoxapine (Asendin®—Lederle): Amoxapine is indicated for the treatment of depression and accompanying anxiety. Clinical studies have shown that it has a more rapid onset of action than either amitriptyline or imipramine. Amoxapine is contraindicated in patients with hypersensitivity to dibenzazepine compounds and in the acute recovery phase following myocardial infarction. It should be used with caution in patients with history of urinary retention, angle closure glaucoma or increased intraocular pressure.

Adverse Reactions: The most frequent adverse reactions noted include drowsiness, dry mouth, constipation and blurred vision. Less frequently reported adverse effects include anxiety, insomnia, restlessness, nervousness, palpitations, tremors, confusion, excitement, nightmares, ataxia, alterations in EEG patterns, skin rash, edema, nausea, dizziness, headache, fatigue, weakness, excessive appetite and increased perspiration. Consult the package insert for a complete listing of less frequent adverse effects.

Interaction Potential: Monoamine oxidase inhibitors should not be administered concurrently with amoxapine as hyperpyretic crises and severe convulsions have been reported. Paralytic ileus has been reported when tricyclic antidepressants are taken in combination with other anticholinergic agents. Amoxapine may enhance response to alcohol, barbiturates and other CNS depressants.

Dosage: The adult dosage is 50 mg three times a day, not exceeding 300 mg.

Availability: Amoxapine is supplied as 50 mg, 100 mg and 150 mg tablets.

Calcifediol (Calderol®—Upjohn): Calcifediol is the monohydrate of 25-hydroxycholecalciferol. It is indicated for the treatment and management of metabolic bone disease associated with chronic renal failure. It is contraindicated in patients with hypercalcemia or evidence of vitamin D toxicity. Other vitamin D derivatives should not be administered concomitantly. Safety of calcifediol in pregnant women, nursing mothers and pediatric patients has not been determined.

Adverse Reactions: The adverse reactions noted, in general, are similar to those encountered with excessive vitamin D intake, hypercalcemia, hypercalciuria and hyperphosphatemia. Adverse effects reported early in therapy include

weakness, headache, somnolence, nausea, vomiting, dry mouth, constipation, muscle pain, bone pain and metallic taste. Other adverse effects seen later in therapy include polyuria, polydipsia, anorexia, irritability, weight loss, nocturia, conjunctivitis, pancreatitis, photophobia, rhinorrhea, pruritus, hyperthermia, decreased libido, elevated BUN, albuminuria, elevated SGOT and SGPT, hypertension, cardiac arrhythmias and rarely overt psychosis.

Interaction Potential: Cholestyramine has been reported to reduce absorption of fat-soluble vitamins and thus calcifediol absorption may be decreased. Calcifediol should be given cautiously to patients receiving digitalis because hypercalcemia in such patients may precipitate cardiac arrhythmias. Phenytoin and barbiturate anticonvulsants may increase metabolic inactivation of vitamin D thus increasing calcifediol requirements.

Dosage: The optimal daily dose of calcifediol must be carefully determined for each patient. For the treatment of chronic renal failure and patients being dialyzed, the initial dosage is 300-350 mcg administered weekly on a daily or alternate day schedule. See package insert for complete dosage schedules.

Availability: Calcifediol is available in 20 mcg and 50 mcg capsules for oral administration.

Calcium polycarbophil (Mitrolan®—Robins): Calcium polycarbophil is a bulk laxative and antidiarrheal which restores normal stool consistency by retaining free water in the lumen of the intestine and indirectly opposes dehydrating forces of the bowel. It is indicated for the treatment of constipation or diarrhea associated with conditions such as irritable bowel syndrome, diverticulosis and acute non-specific diarrhea. It is contraindicated in patients with signs of gastrointestinal obstruction.

*The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm. D.; M.J. Berger, R.Ph., M.S.; G. Chishti, M. Pharm., M.S.; H.L. Kirschenbaum, M.S., Pharm. D.

Adverse Reactions: Abdominal fullness is occasionally noted. This may be relieved by administering smaller, more frequent doses.

Interaction Potential: None reported to date.

Dosage: Dosage should be adjusted according to individual response. The tablets should be chewed and swallowed. The usual adult dose is two tablets four times a day, not to exceed 12 tablets per day. For severe diarrhea, the dosage may be repeated every half hour, but should not exceed 12 tablets per day. Refer to the package insert for pediatric dosages.

Availability: It is supplied in chewable tablets each containing 500 mg of polycarbophil.

Clocortolone pivalate (Cloderm®—Ortho): Clocortolone pivalate is a synthetic corticosteroid in a water-washable, emollient cream base. The drug possesses anti-inflammatory, antipruritic and vasoconstrictive actions, and is indicated for relief of the inflammatory manifestations of corticosteroid responsive dermatoses. It is contraindicated in those patients with a history of hypersensitivity to any of its components. If irritation develops, the product should be discontinued. Safety during pregnancy has not been established. See package insert for complete listing of precautions.

Adverse Reactions: Local adverse reactions have been reported with topical corticosteroids, and include burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae and miliaria.

Interaction Potential: None was reported as yet.

Dosage: Apply sparingly to the affected areas three times a day. In resistant cases, it may be applied more frequently—or use occlusive dressing technique. See package insert for complete directions.

Availability: Clocortolone pivalate cream 0.1 percent is supplied in tubes containing 15 grams and 45 grams.

Daunorubicin hydrochloride (Cerubidine®—Ives): Daunorubicin is an antibiotic indicated for remission induction in acute nonlymphocytic leukemia in adults. It is contraindicated in patients with preexisting drug-induced bone marrow suppression. It should be used with caution in patients with preexisting heart disease or previous therapy with doxorubicin. Daunorubicin is known to be teratogenic, and if used during pregnancy, the patient should be apprised of the potential hazard to the fetus.

Adverse Reactions: Dose limiting toxicity includes myelosuppression and cardiotoxicity. Other effects are reversible alopecia, nausea, vomiting, diarrhea, fever, chills and skin rash. Extravasation during administration may result in tissue necrosis.

Interaction Potential: None reported.

Dosage: As a single agent daunorubicin is given in a dosage of 60 mg/m² per day intravenously on days one, two and three, every three to four weeks. See the package insert for the complete dosage regimen.

Availability: It is supplied in vials containing five mg daunorubicin to be reconstituted with four ml sterile water for injection.

Dipiverfrin hydrochloride (Propine®—Allergan): Dipiverfrin hydrochloride solution is a 0.1 percent sterile, isotonic ophthalmic solution. It is a member of a class of drugs known as prodrugs. Prodrugs usually are not active in themselves and require biotransformation to a parent compound before therapeutic activity is seen. Dipiverfrin is the prodrug for epinephrine. It is indicated as initial therapy for

the control of elevated intraocular pressure in chronic open-angle glaucoma. Patients responding inadequately to other antiglaucoma therapy may respond to this drug. Therapeutic response to twice daily administration is somewhat less efficacious than two percent epinephrine administered daily, and is comparable to two percent pilocarpine administered four times daily. Dipiverfrin is contraindicated with narrow-angle glaucoma and in patients showing hypersensitivity to any of its components. Safe use in pregnant women, nursing mothers and children has not been established.

Adverse Reactions: Ocular burning and stinging is the most frequent side effect reported with dipiverfrin therapy. Macular edema, tachycardia, arrhythmias and hypertension have been reported with ocular administration of epinephrine and thus may occur with dipiverfrin therapy.

Interaction Potential: None reported.

Dosage: The usual dosage of dipiverfrin is one drop every 12 hours.

Availability: It is supplied as 0.1 percent sterile solution in plastic dropper bottles.

Meclocycline sulfosalicylate (Meclan®—Ortho): Meclocycline sulfosalicylate one percent is a synthetic tetracycline antibiotic in a yellow vanishing-cream base, indicated for the topical treatment of acne vulgaris. It is contraindicated in patients who have shown hypersensitivity to any of its components or to other tetracyclines. As percutaneous absorption after prolonged use may occur, caution should be exercised when administering meclocycline sulfosalicylate to patients with hepatic or renal dysfunction. Safety in pregnancy and nursing mothers has not been established.

Adverse Reactions: Meclocycline is usually well tolerated. Temporary follicular staining may occur with excessive application. There also have been isolated reports of skin irritation and one report of acute contact dermatitis after its use.

Interaction Potential: None was reported after topical use. However, as systemic absorption is possible, caution should be observed when used with other agents known to interact with the tetracyclines.

Dosage: Meclocycline sulfosalicylate should be applied to the affected area twice daily in the morning and evening, although less frequent application may be effective depending upon patient response.

Availability: It is supplied as a one percent cream in 20 gram tubes.

Meclofenamate Sodium (Meclomen®—Parke-Davis): Meclofenamate sodium is a nonsteroidal anti-inflammatory agent indicated for relief of the signs and symptoms of acute and chronic rheumatoid arthritis and osteoarthritis. Since it has a potential to produce severe gastrointestinal effects, it is not recommended as the initial drug of treatment. It is contraindicated in patients who have shown hypersensitivity to it. As a potential of cross-sensitivity exists with aspirin and other nonsteroidal anti-inflammatory drugs, meclofenamate should not be given to patients in whom these drugs induced symptoms of bronchospasm, allergic rhinitis or urticaria. Meclofenamate is not recommended for use during pregnancy or in nursing mothers. Safety and effectiveness in children below age 14 has not been established.

Adverse Reactions: The most commonly associated adverse reactions with meclofenamate involved the gastrointestinal system and were manifested by diarrhea and nausea with or without vomiting and/or abdominal pain. Other gastrointestinal adverse effects include pyrosis, flatulence, anorexia,

constipation, stomatitis and peptic ulcer. Headache, dizziness, rash, edema, urticaria, pruritus, tinnitus, palpitation, malaise, fatigue, paresthesia, insomnia, depression, nocturia and taste disturbances also occur.

Interaction Potential: Meclofenamate enhances the effect of warfarin. Therefore, when it is given to a patient receiving warfarin, the dosage of warfarin should be reduced to prevent excessive prolongation of the prothrombin time. Concurrent administration of aspirin may lower meclofenamate plasma levels, and greater fecal blood loss results from concomitant administration than from either drug alone.

Dosage: The dosage is 200 to 400 mg per day administered in three or four equal doses. See package insert for complete information.

Availability: It is supplied in 50 mg and 100 mg capsules.

Naproxen Sodium (Anaprox®—Syntex): Naproxen sodium is a non-narcotic analgesic with anti-inflammatory and antipyretic action. It is indicated for the relief of mild to moderate pain and for the treatment of primary dysmenorrhea. It is also indicated for the treatment of the signs and symptoms of rheumatoid arthritis and osteoarthritis. Naproxen is contraindicated in patients who have shown hypersensitivity to it. As potential exists for cross-sensitivity reactions, it should not be given to patients in whom aspirin or other nonsteroidal, anti-inflammatory drugs induced the syndrome of bronchospasm, rhinitis or urticaria. Safety during pregnancy has not been established. Caution should be exercised if the drug is administered to a nursing mother. Effectiveness in children has not been established.

Adverse Reactions: The most frequent adverse effects reported in incidences greater than one percent include constipation, heartburn, abdominal pain, nausea, dyspepsia, diarrhea, stomatitis, headache, dizziness, drowsiness, light-headedness, vertigo, edema, dyspnea, and palpitation. Itching, skin eruptions, sweating, purpura, tinnitus, hearing disturbances and thirst also were reported. For less frequent adverse reactions consult the package insert.

Interaction Potential: Short-term controlled studies failed to show that naproxen sodium significantly affects the prothrombin time when administered to individuals on coumarin-type anticoagulants; however, caution is advised, since interactions have been seen with other non-steroidal agents of this class. Similarly, patients receiving hydantoins, sulfonamides or sulfonylureas concurrently with naproxen should be observed for signs of toxicity to these drugs. Concurrent administration of probenecid with naproxen increases the half life of this drug.

Dosage: Recommended dosage for mild to moderate pain and dysmenorrhea is one 275 mg tablet followed by one 275 mg tablet every six to eight hours as required.

Availability: Naproxen sodium is available in 275 mg and 500 mg tablets.

Oxamniquine (Vansil®—Pfizer): Oxamniquine is a tetrahydroquinoline derivative indicated for the treatment of all stages of schistosoma mansoni infections. Oxamniquine should be administered with extreme caution and under medical supervision to patients with a history of convulsive disorders as occasional instances of epileptiform convulsions have been reported. The safety of the drug in pregnancy and nursing mothers has not been fully established.

Adverse Reactions: Oxamniquine is generally well tolerated especially if taken after meals. However, transitory dizziness or drowsiness has occurred in about one-third patients. Other adverse effects noted include headache, nausea, vomit-

ing, abdominal pain, anorexia, and urticaria.

Interaction Potential: None was reported as yet.

Dosage: The recommended adult dosage, given after meals, is 12 to 15 mg/kg as a single oral dose. For children under 30 kg, the recommended dosage is 20 mg/kg given in two doses of 10 mg/kg, two to eight hours apart.

Availability: Oxamniquine is supplied as 250 mg capsules.

Ritodrine hydrochloride (Yutopar®—Merrell-National): Ritodrine hydrochloride is a B_2 -adrenergic agonist. It is indicated for the management of preterm labor. It decreases the incidence of neonatal mortality and respiratory distress syndrome. Ritodrine is contraindicated when known hypersensitivity to any component of the product exists. It should not be given before the 20th week of pregnancy and in those conditions where pregnancy is hazardous to the mother or fetus. The drug should be administered with extreme caution to patients with mild to moderate preeclampsia, eclampsia, hypertension and diabetes. No teratogenic effects were reported.

Adverse Reactions: Most frequent adverse effects associated with intravenous administration of ritodrine are dose related. They include alterations in maternal and fetal heart rates and in maternal blood pressure. Patients with persistent tachycardia or decreased diastolic blood pressure may require withdrawal of the drug. Ritodrine infusion is also associated with transient elevation of blood glucose and insulin. Other frequent adverse effects observed in 10 to 50 percent of the patients include palpitations, tremors, nausea, vomiting, headache and erythema. Occasional and infrequent adverse effects observed with intravenous therapy of ritodrine include nervousness, jitteriness, restlessness, emotional upset, anxiety and chest pain or tightness. Adverse effects reported after oral therapy include increase in maternal heart rate, palpitation, tremor, nausea, jitteriness, rash and arrhythmia. Neonatal adverse effects include hypoglycemia and ileus. Hypotension and hypocalcemia have been reported in some neonates whose mothers were treated with ritodrine.

Interaction Potential: Corticosteroids used concomitantly with ritodrine may lead to pulmonary edema. The effects of other sympathomimetic amines may be potentiated when concurrently administered and thus a sufficient time interval should elapse before administering a sympathomimetic drug to a patient receiving ritodrine therapy. Coadministration of other beta-adrenergic drugs should be avoided as they inhibit its action. The possibility that hypotensive effects may be potentiated should be considered when used with anesthetics in surgery.

Dosage: In the management of preterm labor, the initial intravenous treatment usually should be followed by oral administration. The optimum dose of ritodrine is determined by a clinical balance of uterine response and unwanted effects. The usual initial dose is 0.1 mg/min and may be gradually increased by 0.05 mg/min every ten minutes until desired results are obtained. One 10 mg tablet may be given 30 min. before the termination of intravenous therapy. See package insert for complete dosing information.

Availability: It is supplied in five ml ampules, each containing 50 mg of ritodrine hydrochloride. It is also available in ten mg tablets.

Trifluridine (Viroptic®—Burroughs Wellcome Co.): Trifluridine is an antiviral for topical ophthalmic administration. It is indicated for the treatment of primary and recurrent epithelial keratitis. It is also effective in the treatment of epithelial keratitis resistant to topical vidarabine and

idoxuridine. It is contraindicated in individuals with a history of hypersensitivity to it. Safety in pregnant women and nursing mothers has not yet been established.

Adverse Reactions: The most frequent adverse reactions noted include mild, transient burning or stinging upon instillation (4.6%) and palpebral edema (2.8%). Other adverse reactions include superficial punctate keratopathy, epithelial keratopathy, hypersensitivity reactions, stromal edema, irritation, keratitis sicca, hyperemia and increased intraocular pressure.

Interaction Potential: No interactions have been reported.

Dosage: Instill one drop every two hours while awake until the herpetic lesion has completely reepithelialized, then one drop every four hours for seven days postreepithelialization. Continuous administration of trifluridine for periods exceeding 21 days should be avoided because of potential ocular toxicity.

Availability: It is supplied as one percent sterile ophthalmic solution in a plastic Drop-Dose® dispenser bottle of 7.5 ml.

Trimethoprim (Proloprim®—Burroughs Wellcome; Trimplex®—Roche): Trimethoprim is a synthetic anti-bacterial agent indicated for treatment of initial episodes of uncomplicated urinary tract infections due to susceptible organisms. It is contraindicated in individuals who are hypersensitive to it and in patients with documented megaloblastic anemia due to folate deficiency. Trimethoprim also should be given with caution to patients with impaired renal or hepatic function. It should be used during pregnancy only if potential benefit justifies the potential risk to the fetus. It is excreted in human milk and should not be given to nursing mothers. The safe use of the drug in children under 12 years of age has not been established.

Adverse Reactions: The most common adverse effects noted are rash and pruritus. Other adverse effects encountered involve the gastrointestinal and hematopoietic systems. Miscellaneous reactions reported include fever, elevation of serum transaminases, bilirubin, BUN and serum creatinine levels.

Interaction Potential: No interactions were reported to date.

Dosage: The usual oral adult dose is 100 mg of trimethoprim every 12 hours for ten days.

Availability: It is supplied in 100 mg white tablets.

Zomepirac sodium (Zomax®—McNeil): Zomepirac sodium is a nonsteroidal antiinflammatory agent indicated for the relief of mild to moderately severe pain. It is contraindicated in patients who have previously exhibited intolerance to it and should be avoided in patients in whom aspirin and other nonsteroidal anti-inflammatory drugs have induced sensitivity reactions. Zomepirac sodium should be used with extreme caution in patients with a history of upper GI tract disease, as GI bleeding and ulcerations have occurred. Caution should be exercised in patients with impaired renal function, fluid retention, hypertension, heart failure, coagulation disorders and in whom chronic use is contemplated.

Adverse Reactions: The incidence of adverse reactions is substantially greater in patients receiving long-term therapy (more than one week) rather than short-term therapy. The most frequent adverse reaction noted with long-term therapy was nausea. Other adverse reactions noted include GI distress, diarrhea, abdominal pain, dyspepsia, constipation, flatulence, vomiting, dizziness, insomnia, edema, elevated blood pressure, rash, asthenia, and urinary tract infections. Consult the package insert for a complete listing of adverse effects.

Interaction Potential: The concurrent use of zomepirac sodium and aspirin is not recommended.

Dosage: The recommended adult dose of zomepirac sodium is 100 mg every four to six hours as required. For the treatment of mild pain, 50 mg every four to six hours may be sufficient. Single doses greater than 100 mg are not recommended.

Availability: Zomepirac sodium is available as scored hexagonal 100 mg tablets.

Medicaid Rule Proposals

The following notices of rule proposals have been provided by the Division of Medical Assistance and Health Services, 324 East State Street, Trenton. These proposals were published in the May 7, 1981 issue of the *New Jersey Register*. All of the proposals are prospective in nature.

1. Procedure Code Manual

The Division of Medical Assistance and Health Services is proposing changes to the Procedure Code Manual which will affect physicians and optometrists.

These proposed changes will include elimination of time parameters as a factor in determining reimbursement (except for procedure codes 9030 and 9071); elimination of geographical divisions within the State; and the establishment of parity in fee schedule for both institutional, office and home visits services.

2. Common Claim Form—HCFA-1500

The Health Care Financing Administration of the U.S. Department of Health and Human Services has recommended usage of a common claim form designated HCFA-1500. The Division of Medical Assistance and Health Services plans to commence using this claim form on or about July 1, 1981.

The HCFA-1500 form will replace the MC-8 form, which is the one currently being used by the Division.

Providers will be allowed to use their existing MC-8 forms until they order a new supply of claim forms. They will then receive the HCFA-1500 forms.

The HCFA-1500 is intended to simplify billing procedures for physicians and other practitioners. It is also intended to facilitate processing of claims involving recipients who have both Medicare and Medicaid coverage.

The Division will incur the administrative costs of printing the HCFA-1500 forms. It is not anticipated there will be any cost to the providers.

3. Automated Billing System

The Division of Medical Assistance and Health Services is proposing new rules to allow approved providers to submit Medicaid claims via an approved

method of automated billing.

This provision will be optional thereby allowing providers to select a method of billing that is cost effective for them.

Providers *must* obtain approval from the appropriate contractor, either Prudential Insurance Company or Blue Cross of New Jersey, before they will be allowed to submit claims via an automated method.

4. Use of Service Bureau or Management Agencies

The Division of Medical Assistance and Health Services is proposing an amendment (to N.J.A.C. 10:49-1.13 and 1.14) to allow providers to utilize a service bureau and/or management agency when billing the Medicaid program.

This provision will be optional, not mandatory. *Providers who use this method of billing must obtain prior approval from the Division of Medical Assistance and Health Services.*

5. Elective Surgical Procedures—Second Opinion

The Division of Medical Assistance and Health Services is *proposing* a regulation requiring a second opinion, to be rendered by a board-certified specialist, on certain elective surgical procedures. A complete list of the procedure codes was printed in the New Jersey Register on May 7, 1981.

Hospitals and physicians who fail to obtain the required second opinion on the specified procedures will not be reimbursed.

6. Provider Status—Relocation Notification

The Division of Medical Assistance and Health Services is proposing regulations requiring providers to notify the Division of Medical Assistance and Health Services whenever there is a change in provider status.

Changes include relocation of place(s) of business, and change in ownership and/or operation.

Providers who fail to provide the required notification within the specified time periods may become "non-approved" providers, thereby causing their claims to be disallowed.

This proposed regulation is designed to further the objectives of federal regulations (42 CFR 431.107) which require each provider to execute an agreement with the State Medicaid Agency, and to comply with the disclosure provisions specified in 42 CFR 455, Subpart B.

7. Procedure Codes for Ophthalmologists and Optometrists

The Division of Medical Assistance and Health Services is proposing a regulation which will require ophthalmologists and optometrists to use the applicable procedure code corresponding to the narrative description when submitting a Medicaid claim.

It is anticipated the use of procedure codes will result in faster, more accurate claims processing.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

It is heartening to report that new physicians who have completed their education at CMDNJ continue to favor New Jersey in increasing numbers. Of those who received their degrees in May, 170 will be joining the housestaffs of New Jersey hospitals this month.

Excluding seven graduates who will be entering military service, the number of those staying in New Jersey represents slightly more than half of all those who entered postgraduate training at civilian institutions. The number also represents an increase by 14 over the number of new graduates who stayed in New Jersey last year for residency programs. In 1980, 155 CMDNJ-trained physicians—also 50 percent, excluding military—chose New Jersey residencies.

The largest percentage of new graduates staying in the State are those of the first graduating class of the CMDNJ-New Jersey School of Osteopathic Medicine. Of the 24 new D.O.s, 20—more than 83 percent—have opted to do their internships at John F. Kennedy Memo-

rial Hospital in Stratford, the school's core teaching hospital in South Jersey, which has been identified as the most medically underserved area in the State.

Once again, it is gratifying to see that the emerging pattern has not affected the continuing trend toward larger numbers of New Jersey-born and New Jersey-educated physicians remaining in the State to continue their training and, eventually, to set up their practices. The number has been rising steadily since 1970, the founding year of CMDNJ, when only 21 New Jersey medical graduates, which was about one-third of the class, remained in the State for post-graduate training.

The 343 new physicians who graduated this year included, in addition to the osteopathic physicians, 132 graduates of the CMDNJ-New Jersey Medical School, Newark; 96 graduates of the CMDNJ-Rutgers Medical School, Piscataway, and 91 physicians in the Fifth Pathway, a program which provides a year of intensive clinical training to American graduates of foreign medical schools.

The continuing popularity of New Jersey residency programs bodes well for the future of health care in the State, since young physicians tend to set up practice in the area where they receive their training. Largely responsible for the trend are the growth of enrollment in the State's medical education programs and CMDNJ's commitment to improving health care in its base communities.

Since 1970, when the College's total enrollment was 556, the number of students pursuing professional degrees in CMDNJ programs has tripled. The College's phenomenal growth during its first decade is accounted for by the construction of new facilities, expanded affiliations with community hospitals and development of educational programs. It is expected that the college-wide enrollment will reach 2,000 by 1985.

CMDNJ MEDAL

At the commencement exercises held at the Garden State Arts Center in Holmdel on May 29, we received personal satisfaction as well as sharing a deep sense of gratitude in awarding, on behalf of the Board of Trustees of CMDNJ, the first CMDNJ Medal to Governor William T. Cahill. The former Governor was honored for distinguished service and leadership in the development of health sciences education for New Jersey.

Governor Cahill fostered the plan to unify public health sciences programs in

New Jersey and signed into law the bill which created CMDNJ on June 15, 1970. His actions as Governor crystallized and codified the unique dual mission which has characterized the College throughout its development. At his urging, CMDNJ was established as a freestanding health sciences university, to coordinate and lead educational efforts in the health sciences in keeping with the State's continuing needs. At the same time, the College was to develop a system of health services to fill identified gaps through its own facilities and through cooperation with hospitals and other health resources statewide.

ACP Fellows

The following members of the Medical Society of New Jersey were elected to Fellowship in the American College of Physicians at the annual session in April in Philadelphia:

Salvatore A. Chiaramida, M.D.,

Middlesex

Richard A. Dickey, M.D., Bergen

Anthony A. Donatelli, M.D., Union

Allan N. Krutchik, M.D., Passaic

Carl Restivo, Jr., M.D., Hudson

Ira J. Spiler, M.D., Middlesex

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Parvin Javadi, M.D., P.O. Box 50, Bradford, PA 16701. Pahlavi Medical School (Iran) 1964. Board eligible. Group, partnership, solo, academic. Available.

CARDIOLOGY—Lawrence J. Gessman, M.D., 21 Sabine Avenue, Narberth, PA 19072. University of Pennsylvania 1974. Board certified. Group, partnership (pref-

erably with cardiac catheterization). Available.

G. R. Kolluru, M.D., 914 South Avenue, Apt. E-33, Secane, PA 19018. Andhra (India) 1973. Board certified (IM). Group, partnership, solo. Available.

FAMILY MEDICINE—Allan P. Olivieri, M.D., 120 West 80th Street, New York, NY 10024. Cornell 1976. Board certified. Group, partnership, hospital affiliate (full time). Available.

Louis Verardo, M.D., 21 Walnut Road, Apt. 1—2A, Glen Cove, NY 11542. University of Bologna (Italy) 1978. Board eligible. Group (private or hospital-sponsored), preferably with opportunities for medical school/residency affiliation (for teaching purposes). Available August 1981.

K. J. Smith, M.D., P.O. Box 486, Durham, PA 18039. University of Washington 1976. Board eligible. Group. Available August 1981.

INTERNAL MEDICINE—Prabhakar N. Vaidya, M.D., 7752 Montgomery Road, Apt. 81, Cincinnati, OH 45236. Seth G.S. Medical College (India) 1969. Board certified. Single or multi-specialty group, partnership, or hospital-based. Available.

Lakhu Janimal Rohra, M.D., 86-19 Elmhurst Avenue, Apt. 3-E, Elmhurst, New York 11373. Baroda (India). Board eligible. Solo, associate, group. Available.

M. A. Menon, M.D., 355 Crale Boulevard, #202, Melvindale, MI 48122. Armed Forces Medical College (India) 1974. Sub-specialty, gastroenterology. Board certified. Group, solo. Available.

Bankim D. Shah, M.D., 100 Hospital Plaza, #705, Paterson, NJ 07503. T.N. Medical (India) 1974. Group, partnership, solo. Available.

Rakesh Anand, M.D., 412 Maryland Avenue, Apt. 3-C, Staten Island, NY 10305. Medical Institute, New Delhi (India) 1973. Board certified. Solo, partnership, group. Available on one to two months' notice.

Marzie T. Nejad, M.D., 2200 Benjamin Franklin Parkway, Apt. S-1105, Philadelphia, PA 19130. Tehran University (Iran) 1969. Subspecialty, nephrology. Board eligible. Hospital-based, partnership, group. Available.

NUCLEAR MEDICINE—M. I. Straub, M.D., 254 Frances Street, Teaneck, NJ 07666. Semmelweis (Hungary). Special interest, diagnostic radiology. Board eligible. Available.

OBSTETRICS/GYNECOLOGY—F. Adibi, M.D., 84 Skyline Drive, Chalfont, PA 18914. Tehran (Iran) 1967. Board certified. Group/partnership. Available.

Dilipkumar G. Patel, M.D., 72 Duke Street, New Brunswick, NJ 08901. Baroda (India) 1974. Board eligible. Group, associate, solo, hospital. Available.

Mohammed M. Mohiuddin, M.D., 215 Locksley Road, Syracuse, NY 13224. Osmania (India) 1973. Board eligible. Any type practice except academic position. Available.

Mridu B. Agarwal, M.D., 318 East 15th Street, Apt. 6-A, New York, NY 10003. Lady Hardinge (India) 1971. Solo, group,

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO NICIN® capsule contains:

Pentylenetetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 5 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



or partnership. Available.

Jung Fu Chen, M.D., P.O. Box 218, Petersburg, WV 26847. National Taiwan University 1956. Board eligible. Partnership, solo. Available.

OCCUPATIONAL MEDICINE—Louis Z. Fauteux, Jr., M.D., 294 Carlton Avenue, Piscataway, NJ 08854. Georgetown 1947. Board certified (IM). Board eligible. (OM). Industrial. Available.

PATHOLOGY—Alexander J. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified (AP and CP). Any type practice including institutional. Available.

Aruna Kumar, M.D., 6223-B Newport Avenue, Norfolk, VA 23505. J.L.N. Medical (India) 1972. Board eligible (AP/CP). Group, solo, or partnership. Available.

PEDIATRICS—Anil G. Pradhan, M.D., 118 Grove Park, Fort Dix, NJ 08640. Bombay (India) 1972. Board certified. Solo, partnership, associate, group. Available.

Rajendra C. Parikh, M.D., 77-07 Woodside Avenue, Apt. 3-A, Elmhurst, NY 11373. Baroda (India) 1975. Board eligible. Group, partnership, solo, or institutional. Available.

Shara J. Doshi, M.D., 304 Fir Street, Raceland, Louisiana 70394. B.J. Medical (India) 1969. Board eligible. Solo, group, partnership, clinic. Available.

Fe C. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified. Any type practice. Available.

Yogesh J. Pandya, M.D., 24 Paerdegas—15th Street, Brooklyn, NY 11236. Baroda (India) 1973. Board eligible. Solo, group, partnership, hospital-based. Available.

Susheela Raghunathan, M.D., 9 Weston Place, East Brunswick, NJ 08816. India 1973. Board eligible. Group, institutional, clinic, emergency room, or house staff, student health center. Available.

PSYCHIATRY—Paul L. Maitheny, M.D., 99 Pawnee Road, Lakewood, NJ 08701. University of Graz (Austria) 1951. Board eligible. Available September 1981.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379. Shah (India) 1969. General practice and rehabilitation medicine. Available on three months' notice.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available.

Thomas A. Giangrosso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available.

SURGERY, GENERAL—S. R. Bajina, M.D., E1501, Park Towne Place, 2200 Benjamin Franklin Parkway, Philadelphia, PA 19130. Special interest—gastrointestinal endoscopy. Board certified. Solo, group, institutional-based. Available.

Rajendra M. Agarwal, M.D., 318 East 15th Street, New York, NY 10003. King George's (India) 1968. Solo, group, or partnership. Available.

P. Joshua Mammen, M.D., 404 West 51st Street, Apt. 2-B, New York, NY 10019. Trivandrum (India) 1970. Board eligible. Group, partnership, solo. Available.

B. Paulauskas, M.D., Route 1, Box 273-M, Lake Placid, FL 33852. Lithuania 1972. Special interest, vascular surgery. Board eligible. Group, partnership, solo. Available.

Kong Hua L. Go, M.D., 605 Louisiana Avenue, Apt. 17-A, Brooklyn, NY 11239. Far Eastern (Philippines) 1973. Board eligible. Any type practice. Available.

Job S. Kakkasseril, M.D., 3194 McGill Lane, Cincinnati, OH 45239. Pradesh (India) 1972. Board eligible. Group, solo, or partnership. Available.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available.

Inder J. Singh, M.D., WCMC #1-C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available.

UROLOGY—Harvey Schoenbrum, M.D., 1249 Park Avenue, Apt. 14-A, New York, NY 10029. Pittsburgh 1976. Board eligible. Group, partnership. Available.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available.

Robert D. Zimmerman, M.D., 206 Friar Lane, Clifton, NJ 07013. Chicago Rush-Presbyterian. Board eligible. Partnership, solo, group. Available.

Talluri Balaji, M.D., 1926 West Harrison St., Apt. 916, Chicago, IL 60612. Osmania (India) 1973. Solo. Available July 1982.

Mahendra S. Shah, M.D., 62 Forsythia Lane, Paramus, NJ 07652. Baroda (India) 1968. Board certified. Group or partnership. Available.

Tahmoures Furoozi, M.D., 3646 Tuscola Avenue, Seaford, NY 11783. Esfahan University (Iran) 1966. Board eligible. Any type practice. Available.

A peripheral vasodilator
for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	.....300 mg.
Ascorbic Acid	.....150 mg.
Niacinamide	.....75 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....25 mg.
Pyridoxine HCL (B-6)	.....10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	.....250 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....25 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	.....100 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....25 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Report from the Foundation

Daniel J. O'Regan, M.D.
Medical Director

In May, the Academy of Medicine of New Jersey presented its Edward III Award to James A. Rogers, M.D. Dr. Rogers is well known to his colleagues as a Fellow (Past-President) of the Medical Society of New Jersey, and for his work in establishing continuing medical education on an organized basis in New Jersey. Thanks largely to the work of Dr. Rogers and others in the Academy, New Jersey physicians have available to them a broad spectrum of courses and meetings which enable them to keep abreast of medical developments. It is not necessary to travel far from home to

meet the requirements of the CME programs.

Dr. Rogers is also well known for his interest in professional peer review. The linkage of peer review to continuing education has been one of his prime objectives. It was this concern that led Dr. Rogers to be one of the original founders of the New Jersey Foundation for Health Care Evaluation. All of us join all of you in extending our congratulations to Dr. Rogers.

Another distinguished New Jersey physician deserves a round of applause for his excellent work in a difficult and sensitive job. Sanford M. Lewis, M.D., recently was reelected as Chairman of the Health Care Administration Board (HCAB) by unanimous vote of its members. The HCAB, at its monthly meet-

ings, reviews the proposed regulations of the Department of Health. The subject matter covers most of the influences on delivery, economics, and planning of care. Each topic has advocates on both sides, and Dr. Lewis has conducted thorough discussion with admirable patience and tact. Many physicians in our State are unaware that this sensitive post is manned by one of their colleagues.

At its Annual Meeting in May, the House of Delegates of the Medical Society of New Jersey voted not to continue funding the New Jersey Foundation for Health Care Evaluation. The Foundation wishes to thank Dr. Arthur Krosnick, Editor, and Mrs. Marjorie Treptow, Managing Editor, for their courtesy and valuable assistance in making this space available in *The Journal*.

PERSONAL ITEMS

Dr. Kler Named "Visionary of the Year"

Joseph H. Kler, M.D., of New Brunswick, recently was named "Visionary of the Year 1981" by the Eye Institute of New Jersey, at its Spring Theater Gala held at the Playhouse on the Mall, Paramus. This award is presented to the individual whose work epitomizes the Eye Institute's concern for research and care of the eye.

As a practicing ophthalmologist for fifty years, Dr. Kler consistently has brought his extensive personal experience to larger public needs. He is Director of the Fund for the New Jersey Blind and Chairman of the Board for the New Jersey Commission for the Blind and Visually Impaired.

He also is well known in other areas—he was the first Chairman of the New Jersey Chapter of the American Cancer Society and served on the State Welfare Board since its inception. He has made major contributions as a medical historian and is President of the East Jersey Old Towne architectural restoration, and is an international authority on

medical stamps.

Anticipating the need for a non-profit facility devoted to eye care, Dr. Kler was one of the founders of the Eye Institute of New Jersey. In its ten-year history the Institute has expanded its goals of service, education and research to include twenty out-patient ophthalmology specialty services, such as the New Jersey Eye Bank, an eye pathology laboratory, optical shop, ultrasound suite and low-vision department. The agency is located within the United Hospitals Medical Center in Newark and is affiliated with the New Jersey College of Medicine and Dentistry.

Dr. Breen Honored

James Langhorne Breen, M.D., of Maplewood, clinical professor of obstetrics and gynecology at Jefferson Medical College and chairman of the Department of Obstetrics and Gynecology at Saint Barnabas Medical Center in Livingston, was elected vice-president of

the American College of Obstetricians and Gynecologists at the annual clinical meeting held in April in Las Vegas. Dr. Breen is a fellow of the American Association of Obstetricians and Gynecologists, the American College of Surgeons, the International Academy of Pathology, the American Society of Clinical Pathology and the American Society of Cytology and holds membership in 28 other professional organizations. He has been an examiner for the American Board of Obstetrics and Gynecology since 1966. A guest lecturer at the Universities of Bologna, Rome and the Philippines, Dr. Breen is the author of nearly 150 scientific papers, textbooks, films, and audio-digest lectures on various aspects of his specialty, and has created several award-winning scientific exhibits. He has served with the Medico-Care Program in South Viet Nam and in Afghanistan. For his service in Viet Nam Dr. Breen received the American Medical Association's Meritorious Service Award in 1966, and in 1967 was given the Golden Apple Award of the Student American Medical Association.

Selling Surgical Care

March 27, 1981

My dear Colleagues:

I am moved to write today about a subject that has been disturbing me for some time. It is a subject that I suspect has been upsetting a majority of you as well. This letter is about our colleagues who choose to advertise.

Thirteen years ago I began practice in this state as a plastic and reconstructive surgeon. The task before me, as I saw it in those years, was to practice my specialty with care and awareness of the trust placed in me by the patient and his doctor.

It is perfectly true, that from time to time, I would volunteer to talk to various groups of doctors about the techniques of plastic and reconstructive surgery. These talks were based on the belief that the patients' best interests were served by speaking to their personal physicians. (For it was then widely held that "doctor knows best" as patients would generally ask their family physician's advice before seriously contemplating a surgical operation.)

Well, times have changed, haven't they? Today, patients go directly to a surgeon. Some don't bother to ask their family doctor's opinion. Some ignore their doctor's advice or recommendations. Some read an article in a magazine and are off to see someone "in the city." Some see and respond to ads promising cosmetic surgical cures for nose, ear or breast, large or small. Fewer and fewer of our patients ask the opinion of the physician who knows them.

This trend accelerated several years ago when the Federal Trade Commission prompted the Supreme Court of the United States to rule in their favor. This ruling forced professional societies to change their codes of ethics which had previously barred their members from advertising.

Professionals, and doctors in particular, were slow to respond to this relaxation of ethical restraints. I suspect that in New Jersey, most of us noted this event with passing interest, talking about it in

academic terms rather than with serious practical concern for the local consequences. Slowly at first, but with increasing momentum, professional yellow-page advertising began to expand. More often than not, one would pick up a local paper or tune in to a radio or TV program, to see someone we knew being "interviewed": seeming to be selling his surgical wares.

My secretary fancies herself a "clipping service" for from time to time she places magazines and news articles featuring plastic surgery on my desk. She then waits for my reply as I scan the columns and claims. I disappoint her, for thus far I have said nothing. Until this moment I preferred to remain safe and secure within the microcosm of my own practice and patients: rationalizing it all away with the thought that it is not my charge to change it, nor is it my responsibility to respond to it. But rationalizations have a way of sometimes burying anger and resentment until one day someone or something makes you suddenly aware of all you have swallowed. Something is very wrong here and for what it is worth, I am going to speak out about it. No, to shout about it!

1. The selling of surgical care is wrong. It may be legal, but it is wrong to lure people into undergoing a surgical operation.

2. Newspaper articles and ads that displace the advice and trust of the family physician are doing patients a disservice. Surely, the public has a right to know. But wouldn't it be better information coming from institutional spokesmen, rather than a doctor talking about himself and his practice on radio or TV?

3. Meddling outside interests (governmental or otherwise) attempting to influence professional ethics and the doctor-patient relationship are wrong.

4. I have no intention of participating in or condoning any of the above now or in the future, and *I won't keep quiet about it anymore.*

If you agree with me I should like to read about it or hear about it.

1. Doctors, make your views known. Don't suffer in silence as I have until now.

2. Turn your backs on doctors seeking patients by self-service publicity.

3. I would plead to publicize our good works through our organizations, institutions, hospitals and schools. Leave it to the community and our patients at large to speak well of us as individuals.

(signed) Morton H. Goldstein, M.D.

Nutrition Support Team

April 27, 1981

To the Editor:

The Nutrition Support Team at the Saint Barnabas Medical Center surveyed 117 hospitals in New Jersey for hyperalimentation services. A brief questionnaire was sent to the Director of Pharmacy requesting information concerning the involvement of a specific physician, pharmacist, dietitian or nurse with hyperalimentation. The existence of a formal Nutrition Support Team was also ascertained.

The results of the survey are stated below:

Hospitals responding	81.2%
Specific Physician involved	33.6%
Specific Pharmacist involved	62.1%
Specific Dietitian involved	17.9%
Specific Nurse involved	22.1%
Formal Nutrition Support Team	10.5%

Although a pharmacist is involved in the preparation of hyperalimentation solutions in 62.1 percent of hospitals, only 33 percent of the institutions have a specific physician identified with performing hyperalimentation. The percentage of dietitian and nurse involvement is even lower. The Nutrition Support Team at the Saint Barnabas Medical Center concludes that there is generally a need for more professional in-

vovement in nutrition support.

It is hoped that this information will stimulate additional New Jersey hospitals to become more formally involved in Specialized Nutritional Support.

(signed) David W. Bedell, R. Ph.

Murray H. Seltzer, M.D.

Bernadette A. Slocum, B.S.

Emma L. Cataldi-Betcher, M.S.

High Cost of Medical Care

April 30, 1981

Dear Dr. Krosnick:

The question of the "high cost of medical care" is debated by everyone continuously with little or no success. Why? Let me give you some of my thoughts:

The basic question is and always will remain: *"Can the cost of free enterprise medicine be controlled at all?"* Although the final conclusion is a probable "no," it is worthwhile to review all elements involved and see if some might be subject to modification or change. The cost of medicine is subject to many elements, some of them influencing our economy in general and medicine in particular.

Accessibility: In recent years, the number of physicians increased to a level that they are available in most communities, but there is still some deficiency in distribution of medical manpower. Metropolitan areas have a larger share of physicians than rural areas and large cities certainly have a great concentration of physicians, although not necessarily equally distributed. Being in a free enterprise, *there is no way this can be changed*, except by financial stimulation and incentives.

Inflation: The inflation which affects our everyday life certainly affects the cost of medicine. In addition, it is very likely that medicine itself contributes generously to inflation. *Inflation has to be dealt with* in general terms involving our whole economy.

Technology: In the past 25 years, medicine progressed more than it has in the past 200 years. This is particularly true of American medicine. The time when American physicians traveled to Vienna and London changed. Now, physicians from all over the world come to our country to learn and see for themselves "the best medical care in the world" in

action. Medical technology reached a level which went beyond one's dreams just some years ago, and this certainly is expensive. In a free enterprise, *"monetary incentive" assures us of future progress* and continued excellence. This incentive cannot and should not be changed.

Demand: "The more we have the more we want" is true in our everyday life and certainly in what we expect from medicine today. It is not unheard of being asked by a patient "Can I have a CAT Scan to see if everything is alright with me?" Patients demand excellence in medicine and expect the whole armament of medical knowledge at their disposal, even for a simple cold. *Education of the public* might be able to change this trend and return it to a reasonable level.

Defensive Medicine: In recent years, legal action against physicians has increased. This in turn increased insurance premiums, over 50 times in some cases. It is no wonder that, as in any free market, the cost of insurance was reverted to the "customer," the patient himself. In addition, sometimes unnecessary medical tests are ordered "by the pound" to make sure that "nothing was missed." *Education of the public and elimination of contingency fee* to attorneys might change the present trend.

Physician Fee Profile: There is no way to determine the value of cardiac defibrillation, except that if it is done to "me" it's worth all the money in the world. Physician charges are usually determined by specialty, age, experience, and location, but most of all by *self-discipline* of physicians to know what is right and what is wrong. Unfortunately, there are some among us who are unable to withstand the temptation of free enterprise and the "sky is the limit" when it comes to charging a patient. *Self-discipline, education, peer pressure, and judicial actions* must be used before some physician actions will ruin all of us.

Finally, it might be worthwhile to consider eliminating the daily charges by physicians to patients in the hospital to a DRG type of payment system where prolonged hospitalization will not be to the best interest of the attending physician.

I believe that the HMO concept is the right thing in the right direction. Unfortunately, like everything new, it is being fought by most physicians. They claim that they do not want "control by anyone" and fail to see that, if they do

not control themselves, the present trend of increasing Government control will have to continue.

Everyone is entitled to the best possible medical care our country offers. This cannot be limited only to those who can afford it. The system has to be changed so "everyone" can benefit from necessary health care not as a "charity" and not as a "right," but by being an active participant. We physicians must do our share in forming this great enterprise.

(signed) Gabor Somjen, M.D.

Society Changes Name

May 20, 1981

Dear Sir:

At the Annual Meeting of "The Society for the Relief of Widows and Orphans of Medical Men of New Jersey" held in conjunction with the Annual Meeting of MSNJ, the membership voted to change the name of the Society to indicate more accurately that the function of the Society is to serve the families of deceased male and female physician members.

The new name of the organization will be "The Society for the Relief of Families of Physicians of New Jersey." The name change is to become effective at the next annual meeting which will be held in May, 1982, at Atlantic City. At this meeting, this voluntary charitable organization will celebrate its one hundredth anniversary of service to New Jersey physician members and their families.

The Society continues to be administered by physician volunteers who are willing to extend a helping hand to other physician members or the families of deceased physician members who experience adversity. The Society currently provides support to two widows of physicians. It has provided direct grants in aid to a New Jersey medical student who successfully achieved graduation this June. It provided death benefits to thirty physician families during the past year.

New Jersey physicians, who are not presently members and who wish to participate in this successful ninety-nine year old charitable enterprise endeavor may contact the undersigned (2 Princess Rd., Lawrenceville, NJ 08648).

(signed) James E. D. Gardam, M.D.



MEET THE PROFESSORS

Wednesdays, 4 to 7 p.m.

October 14 to December 23, 1981
(No Session November 25)

Course Directors:

Saul J. Farber, M.D.,

Frederick H. King Professor of Internal Medicine and Chairman, Department of Medicine

Louis Shenkman, M.D. *Associate Professor of Medicine*

COURSE DESCRIPTION

This new course, replacing Consultations in Internal Medicine, is designed to provide even greater interchange between NYU faculty from diverse specialty areas and physicians in internal medicine and family medicine. Each 3-hour session will consist of a distinct unit covering a variety of topics of current interest and controversy. Faculty have been specifically requested to describe "How I Do It," as well as recognizing differing viewpoints. The course experience will enhance the effectiveness of the day-to-day decision making required of practicing physicians.

Each session will begin with capsule presentations for which written handouts, case reviews or blackboard illustrations may be utilized followed by open discussion. To make the interchange more informal, registration will be strictly limited to 60 participants.

TOPICS

Arthritis: Diagnosis and Treatment

Management of the Diabetic

New Diagnostic and Interventional
Tools Available from the Radiologist

Coronary Artery Disease—1981

Antithrombotic Drugs:
Specific Prophylactic Choices for
Arterial and Venous Thromboemboli

Present Concepts and Therapy of
Hepatitis and Peptic Ulcer Disease

Managing Clinical Problems
in the Elderly

Breast and Melanoma Surgery:
Options and Recommendations

Current Use of the Newer Antibiotics

Common Medical Emergencies—
Practical Lessons from the
Emergency Room

FEE: \$490

30 Category I credit hours; 30 AAFP prescribed credit hours (pending).

ALSO

CLINICAL TUTORIAL

152. Dermatology for the Practicing Physician

Thursdays, 1:30 to 3:30 p.m.

October 22 to November 19, 1981

David L. Ramsay, M.D., *Associate Professor of Dermatology*

Specifically designed for non-dermatologic physicians, especially those involved in primary care practice. Major emphasis is on unraveling diagnostic possibilities in a presenting dermatological complaint and providing practical guidelines for relieving the patient's symptoms and promoting resolution while the evaluation is proceeding. Special attention is given to the most commonly encountered dermatological problems in general office practice. Teaching includes lectures, live case presentations, group discussions and a forum for presenting diagnostic and management problems from the registrant's practice.

FEE: \$180

10 Category 1 credit hours; 10 AAFP prescribed credit hours (pending).

Physicians may enroll in one or both of these post-graduate courses.

For further information, write or call:

NYU Post-Graduate Medical School
550 First Avenue, New York, NY 10016
(212) 340-5295 (24-hour telephone service)

JMSNJ 7/81

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Sept.

- 8 New Developments in Analgesia
7-8 p.m.—Saddle Brook General Hospital
(*Saddle Brook General Hospital and AMNJ*)
- 26 Total Nutritional Replacement
- 27 8 a.m.-5 p.m.—Resorts International Hotel, Atlantic City
(*CMDNJ-NJ Medical School and AMNJ*)

CARDIOLOGY

Aug.

- 7 New Cardiac Drugs
12 noon—Freehold Area Hospital
(*AMNJ*)
- 14 Peripheral Vascular Disease
11 a.m.—South Bergen Hospital, Hasbrouck Heights
(*AMNJ*)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Aug.

- 5 Proper Use of Blood Gases
12 noon—Warren Hospital, Phillipsburg
(*AMNJ*)
- 6 Adolescent Alcoholism
9 a.m.—Freehold Area Hospital
(*AMNJ*)
- 7 New Cardiac Drugs
- 21 Evaluation and Diagnosis of Dermatitis
12 noon—Freehold Area Hospital
(*AMNJ*)
- 11 Newer Antibiotics
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(*Shore Memorial Hospital and AMNJ*)
- 14 Peripheral Vascular Disease
11 a.m.—South Bergen Hospital, Hasbrouck Heights
(*AMNJ*)
- Symposium in Internal Medicine
- 18 9 a.m.-2:30 p.m.—VA Medical Ctr., Lyons
- 19 8:30 a.m.-10 a.m.—VA Medical Ctr., Lyons
- 11 a.m.-12:30 p.m.—Medical Grand Rounds, Middlesex General Hospital, New Brunswick

(*CMDNJ-Rutgers Medical School, VA Medical Center, Lyons and AMNJ*)

Sept.

- 2 Dinner Meeting—Endocrinology Section, AMNJ
6-9:30 p.m.—Holiday Inn, East Orange
(*AMNJ*)
- 2 Endocrine Conferences
- 9 3:30-5 p.m.—Rotates between Newark
- 16 Beth Israel Medical Center, College
- 23 Hospital, Newark and VA Medical
- 30 Center, East Orange
(*AMNJ*)
- 3 Adolescent Drug Addiction
9 a.m.—Freehold Area Hospital
(*AMNJ*)
- 4 Thrombolytic Therapy in Pulmonary Embolism
- 15 Dissecting Aneurysm of the Aorta
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 9 Clinical Immunology
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 18 Emergency Care/Diagnosis and Treatment of Shock
12 noon—Freehold Area Hospital
(*AMNJ*)
- 21 Interpretative Problems in Upper GI Tract Disease
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 22 Dermatology
8 p.m.—Warren Hospital, Phillipsburg
(*AMNJ*)
- 30 Corticosteroid Therapy
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)

NEUROLOGY/PSYCHIATRY

Aug.

- 5 Ongoing Child Psychiatry
- 12 Case Conference and Lecture
- 19 8:30-10:30 a.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 26 Hospital
- 8 Transactional Analysis
- 13 Gonadal Steroids for Chronic Endogenous Depression
- 20 Placebo Response
- 23 Homosexuality, Transvestism and Transsexualism
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)

Sept.

- 1 Violent and Assaultive Patients
9:15 a.m.-4:30 p.m.
(*Carrier Foundation and AMNJ*)
- 2 Ongoing Child Psychiatry

Case Conference and Lecture

8:30-10:30 a.m.—Trenton Psychiatric Hospital

(*Trenton Psychiatric Hospital and AMNJ*)

3 Physical Activity and Cardiovascular Health

10 Hypertension

24 Patient Care: Update

12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)

8 Psychiatric Emergencies and Use of Psychotropic Drugs

1-2 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)

8 Antibiotics

22 Emergency Care

11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)

17 EEG Technology and Practice Series

7-9 p.m.—Middlesex General Hospital, New Brunswick
(*EEG Society of NJ and AMNJ*)

26 Pain—Twenty-First Annual Carrier Foundation Symposium

9:15 a.m.-4:30 p.m.—Scanticon-Forrestal Executive Conference Center, Rt. 1, Princeton
(*Carrier Foundation and AMNJ*)

27 Pain—Companion Workshop to Symposium

9:45 a.m.-4 p.m.—Carrier Foundation
(*Carrier Foundation and AMNJ*)

PEDIATRICS

Sept.

22 Prevention of Atherosclerosis—Pediatrics Lecture Series

8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(*St. Joseph's Hospital and Medical Center and AMNJ*)

RADIOLOGY

Sept.

13 Visiting Professorship Program

1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(*St. Barnabas Medical Center and AMNJ*)

26 Basic Echocardiography

27 9 a.m.-5 p.m.—Nassau Inn, Princeton
(*The National Foundation for Non-Invasive Diagnostics and AMNJ*)

GENERAL SURGERY

Sept.

10 Tumor Conference

12 noon-1 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)

CME

See Below

See Page 555

See Page 564

Annual New Jersey American
College of Emergency Physicians

EMERGENCY DEPARTMENT NURSES'S ASSOCIATION SYMPOSIUM

October 1 and 2, 1981

Atlantic City, New Jersey

Physician Fee: \$160 ACEP Members

\$200 Non-Members

For Information Contact:

Linda Bartolo, N.J. Academy of Medicine
(609) 986-1717

KESSLER INSTITUTE FOR REHABILITATION

West Orange, New Jersey

*Affiliated with the College of Medicine and
Dentistry of New Jersey*

A voluntary, non-profit specialty hospital founded in 1949 serving physically handicapped children and adults. Intensive and comprehensive medical services are provided to inpatients and outpatients; services include social, psychological and vocational services for patients with spinal cord injuries, stroke, amputations or any physical impairment due to congenital condition, accident or disease.

Total facilities include a 76-bed inpatient wing; separate outpatient department; complete hydrotherapy unit; complete speech and audiology services; comprehensive outpatient amputee and urological services.

Fully accredited by the Joint Commission on Accreditation of Hospitals and the Commission on Accreditation of Rehabilitation Facilities.

Provider of hospital services under Medicare and Medicaid.

* * * *

ADMISSION BY MEDICAL REFERRAL TO DIRECTOR OF ADMISSIONS

* * * *

RICHARD A. SULLIVAN, M.D., Medical Director
KENNETH W. AITCHISON, Executive Director

Telephone: (201) 731-3600

use the Experienced Laboratory



SOUTH MOUNTAIN LABORATORIES • INC

for CONTROL-RESEARCH

SERVICES IN

- PHARMACOLOGY
- ENDOCRINOLOGY
- TOXICOLOGY
- COSMETICS
- BIO-ASSAY
- PLASTIC IMPLANT
- HUMAN SKIN TESTING
- PYROGENS

380 Lackawanna Pl., South Orange, N.J. 07079 (201) 762-0045

1102 Industrial Parkway, Bricktown, N.J. 08723 (201) 458-0031

Dr. Gerard Balakian

A member of our Bergen County component, Gerard Balakian, M.D., of West Englewood, died on April 10. A native of Turkey, born in 1920, Dr. Balakian emigrated to the United States as a young man and earned his medical degree from Long Island College of Medicine, class of 1944, after which he pursued a residency in internal medicine. He held staff appointments at the Englewood Hospital in the department of medicine and in the cardiac and diabetes clinics. During World War II, Dr. Balakian served in the medical department of the AUS.

Dr. S. Paul Coccia

At the untimely age of 54, S. Paul Coccia, M.D., a member of the Somerset County component, died on May 1 at Middlesex General Hospital in New Brunswick. A native of New Jersey, Dr. Coccia was graduated from Jefferson Medical College, class of 1955, and came to Bound Brook the next year to establish a family practice. He was one of the organizers of the Raritan Valley Hospital and a member of its staff and was affiliated also with the Middlesex General Hospital. Certified by the American Board of Family Practice, he was an instructor in clinical medicine at Rutgers Medical School and had been a charter member of the Academy of Family Physicians. Dr. Coccia was active in civic affairs and at the time of his death was serving on the Middlesex Board of Health and was involved actively in the development of the Health Fair Program at the Middlesex High School. During World War II he served in the Army Air Force.

Dr. John W. Forline

We just have learned of the tragic death, in Egypt on April 21, of John W. Forline, M.D., who died when a tourist boat he was aboard capsized on the Nile River during a storm. A native of Connecticut, Dr. Forline was graduated from Duke University Medical School,

class of 1959, and after two years of duty with the medical department of the US Air Force, pursued residencies in dermatology at the Cincinnati General Hospital (Ohio), the Bronx Veterans Hospital and Mt. Sinai Hospital in New York. He came to New Jersey to establish a practice in Belleville and was affiliated with the Clara Maass Memorial Hospital. Dr. Forline was a member of the Essex County component.

Dr. Winthrop H. Hall

Notice has been received of the death, at Rahway Memorial Hospital on March 28, of Winthrop Huntington Hall. A native of New Jersey, Dr. Hall earned his medical degree from the University of Virginia School of Medicine, class of 1931, and pursued a residency in radiology at Philadelphia General Hospital, earning board certification in that specialty. He had been on the staff at the Rahway Memorial Hospital, the Orange Hospital Center, the Morristown Memorial Hospital and the Muhlenberg Hospital in Plainfield. Dr. Hall was a Fellow of the American College of Radiology and a member of the Radiological Society of North America and of the New Jersey Society of Radiologists. During World War II, Dr. Hall served with the medical department of the United States Navy. He was 76 years old at the time of his death and was a posthumous recipient of MSNJ's Golden Merit Award at the recent Annual Meeting.

Dr. M.F. Hubach, Jr.

One of Essex County's senior members, Maximilian F. Hubach, Jr., M.D., died on April 30 at his home. A native of New Jersey, born in 1905, Dr. Hubach was graduated from Columbia University's College of Physicians and Surgeons in 1932 and established a practice in internal medicine and cardiology in Bloomfield, which he maintained for 45 years, retiring in 1978. He was a former medical director of St. Vincent's Hospital in Montclair and had been on the staff also at Mountainside and Community Hospitals there. Dr. Hubach was

a Fellow of the American Geriatrics Society, a member and former trustee of the American Heart Association, and a member of the Academy of Medicine of New Jersey.

Dr. Edward T. Lynch

We just have learned of the death on March 23 of one of Union County's senior members, Edward T. Lynch, M.D., of Elizabeth. A native of New Jersey, Doctor Lynch was graduated from Jefferson Medical College, class of 1931, and pursued a general practice, with special interest in obstetrics. He was a Fellow of the American College of Obstetricians and Gynecologists and had been affiliated with Alexian Brothers, St. Elizabeth and Elizabeth General Hospitals. The MSNJ Golden Merit Award was bestowed on Dr. Lynch posthumously at the recent annual meeting held in Secaucus. He was 76 years old at the time of his death.

Dr. George A. Maggio

George A. Maggio, M.D., a member of the Essex County component and retired medical director of the Hunterdon State School at Clinton, died on April 16 at the House of the Good Shepherd in Hackettstown. Born in 1907, Dr. Maggio was graduated from George Washington University, class of 1931, and pursued a career in pediatrics, becoming board certified in that specialty. He had a private practice in Newark and was affiliated with St. James, Babies', Columbus and St. Michael's Hospitals (having served as director of the pediatric department at the latter) before accepting appointment at the state school. Dr. Maggio was a member of the Academy of Medicine of New Jersey. MSNJ's Golden Merit Award was bestowed on Dr. Maggio posthumously at the recent annual meeting in Secaucus.

Dr. Thomas A. Sanfacon

The former chief of ophthalmology at St. Joseph's Hospital in Paterson,

Thomas A. Sanfacon, M.D., died on May 3 after a long illness. A native of Grand Isle, Maine, Dr. Sanfacon earned his medical degree from Georgetown University Medical School in 1927 and, following residencies at New York Polyclinic Hospital and the Brooklyn Eye and Ear Hospital, practiced ophthalmology for 45 years in Paterson. He had earned certification by the American Board of Ophthalmology and was a member of the American Academy of Ophthalmology and Otolaryngology. Dr. Sanfacon was 78 years old at the time of his death.

Dr. Clifford M. Schmidt

One of Sussex County's senior members, Clifford M. Schmidt, M.D., of Newton, died on May 2 in Sarasota, Florida where he was living in retire-

ment. A native of Iowa, Dr. Schmidt earned his medical degree from the University of Iowa in 1930 and in 1938 came to New Jersey to establish a general practice in Sussex County. He had been on the staff at Newton Memorial Hospital and was a member of the American Academy of Family Practice. Dr. Schmidt was a recipient of MSNJ's Golden Merit Award in 1980 in recognition of his 50 years as a physician. He was 78 years old at the time of his death.

Dr. Richard V. Sims

Richard V. Sims, M.D., of Summit, one of Union County's senior members, died on April 22 after a long illness. A native of Louisiana, Dr. Sims was graduated from Howard University's Medical School in 1933 and came to New Jersey to establish a family practice. He

had been affiliated with Overlook Hospital in Summit until his retirement in 1970.

Dr. Harry B. Wolowitz

Word just has been received of the death, at Chilton Memorial Hospital on May 16, of Harry B. Wolowitz, M.D., a member of our Bergen County component. A native of Brooklyn, born at the turn of the century, Dr. Wolowitz earned his medical degree from Long Island University College of Medicine, class of 1923, and after several years in general practice directed his activities to the field of anesthesiology. A former director of the department of anesthesiology at the Hackensack Hospital, he had been retired since the early 1970s. During World War II, Dr. Wolowitz served for five years in the medical department of the AUS.

BOOK REVIEWS

The Doctors' Case Against the Pill

Barbara Seaman. New York, Dolphin/Doubleday, 1980. Pp 239. (Paperback—\$6.50)

How sharper than a serpent's tooth is a woman's wrath! And how this authoress indulges her wrath against the male obstetrician/gynecologist who has conspired with the pharmaceutical industry to foist upon unsuspecting women a dangerous drug like the contraceptive pill. The introduction reveals how her crusade against the greedy doctors was started by a bizarre anecdote: Careless doctors and nurses refusing to divulge the contents of a packet of laxatives, "stood over" the lactating authoress to ensure that the laxatives would be taken every four hours. The

predictably horrible results upon nursing mother and infant would justifiably make a Trappist monk break his vow of silence as well as launch a career in journalism.

The basic argument or cause concerning the potential dangers of and contraindications to the pill is excellent and worthy of serious discussion by male physicians as well as by female physicians, who also prescribe the pill. However, sixteen chapters of harangue, half-truths, and statistics extracted out of context, spiced with anecdotes, is an insult to the intelligence of adults who are trying to separate fact from fiction and differentiate myth from reality. Each of the potential complications that might possibly be even remotely or cir-

cumstantially related to the pill is vividly portrayed in a separate chapter without the restraint of logic or veracity. Among the more outrageous accusations is that DES is "widely used to dry up . . . milk." Among the more fallacious (if not purposeful) misinterpretations is the exposé that among pill users "early cervical cancer was more prevalent" than among diaphragm users.

This book is not recommended. All of this journalistic flare and energy might better enhance the physical and emotional well-being of abused and misused American women by persuading them to say "no" once in a while if only to decrease the chance of contracting venereal disease.

Jerome Abrams, M.D.

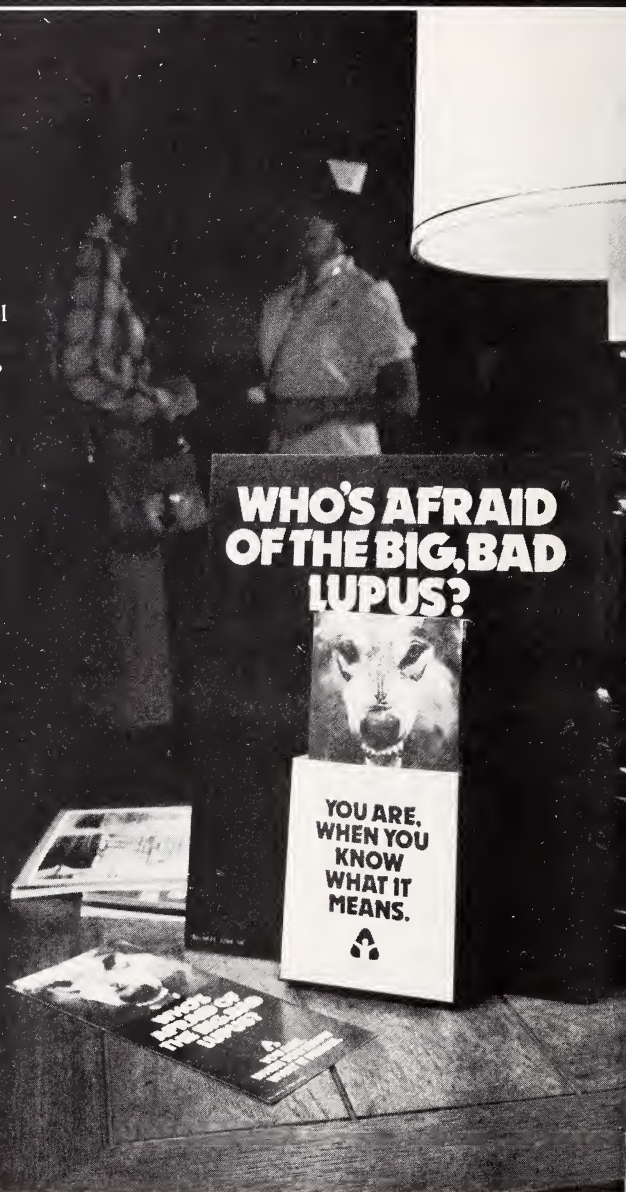
LUPUS FACTS FOR YOUR PATIENTS

Lupus is the subject of a new Arthritis Foundation educational campaign.

The campaign theme is: "WHO'S AFRAID OF THE BIG, BAD LUPUS?... YOU ARE WHEN YOU KNOW WHAT IT MEANS." Using a wolf as an attention getter, we will seek to inform the public about the LUPUS problem in the U.S., and the help that is available. Our literature will provide the warning signs for the disease and our consumer ads and broadcast materials will stress early diagnosis and proper medication and therapy, as the only defense.

We urge your participation in this effort. Our new fact-filled lupus brochure, written for the layman, covers such subjects as what is lupus, the diagnosis of lupus, who gets lupus, the pattern of lupus, signs and symptoms, a management/treatment program and prevention guidelines. Simply order the desired quantities from your local Arthritis Foundation Chapter office, or write "Lupus," Arthritis Foundation, 3400 Peachtree Road, NE, Atlanta, Georgia 30326.

With your help, the impact of this lupus educational campaign will be just what the doctor ordered.



FOR SALE HOME AND OFFICE

13 rooms
6 room house—2½ baths—7 room office
Prime location—Ample parking

contact: Dr. David Elman, 250 Millburn Avenue,
Millburn, N.J. 07041

(201) 376-1772—office or (201) 376-4617—home

IDEAL SPACE FOR PHYSICIAN

750 sq. ft. in new prestigious North Brunswick
building. Will divide to suit.

Please Call 846-6300

Mr. Rosenberg

REDWOOD DECKS

Call Mike

The Fancy Deck Builder

(201) 595-6263

LEASE OFFICE

Ophthalmologist desired to lease office space in a
new medical building. Excellent promise for thriving
ophthalmology practice; suitable for initial
location or as a second office. Please contact:

East Gate Medical Building
Church Street and Gaither Drive
P.O. Box 315
Mt. Laurel, N.J. 08053
609-428-4775

NORTH JERSEY MEDICAL VILLAGE in WAYNE



52,000 sq. ft. of luxury office space designed expressly for
medical professionals and their patients on 4.5 wooded acres
within walking distance from Greater Paterson General Hospital
is open for inspection. The masonry buildings, connected
by interior malls with sky-lights and walkways with wheel chair
ramps, feature:

- offices from 1,000 sq. ft.
- custom-designed layout
- individual climate controls
- burglar, smoke & sprinkler systems
- management office on premises
- coffee shop
- immediate occupancy

Direct Inquiries to: North Jersey Medical Village, 959 Hamburg
Turnpike, Wayne, N.J. 07470 (201) 628-8591

Directions: West on Route 46 or Interstate 80, Route 23 north,
Right on Ratzer Road to Hamburg Turnpike (4 miles), Left
to North Jersey Medical Village at 516 Hamburg Turnpike
(1 mile)

WE HAVE GROWN! HAVE YOU? DOCTORS NEEDED!

Ocean County Population		
1960	1975	1980
108,000	275,000	325,000

N.J. Standard: 1 physician per 1,000 pop.
Ocean County Today: ¾ physician per 1,000 pop.
Ocean County Needs 70-80 Doctors NOW!

We have a 1,200 sq. ft. office available which features a
reception/waiting area, general treatment area, two
examining rooms, surgery room, private office, and
private bathroom. Ideally suited for general practitioner
or specialist.

**CALL (201) 244-9100 OR INFORMATION
1108 HOOPER AVENUE—TOMS RIVER**



MEDICAL SUITES & OFFICES
PRIME LOCATION—MONMOUTH
COUNTY

BETWEEN FREEHOLD HOSPITAL
&
RIVERVIEW HOSPITAL—RED BANK

FIRST FLOOR SUITES
EXCELLENT LIGHTED PARKING
CHAUFFEUR SERVICE AVAILABLE

201-431-1776

NEEMA EMERGENCY MEDICAL
—a professional association—

Emergency Medicine Positions—available with emergency physician group in Pa., N.Y., N.J., Va., W. Va., Md. and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical	
Suite 400	or phone
399 Market Street	in Pa., (215) 925-3511
Philadelphia, Pa. 19106	outside Pa., 800-523-0776

OFFICE SPACE FOR RENT

Office space available next to a Dental Office in a new professional building located on Main Street, Manville, New Jersey. Somerset Medical Center is five minutes away. A town of 14,000 plus, presents an unusual opportunity for an immediately successful practice.

Call (201) 722-2928 for additional information.

Obstetrics and Gynecology physician for Women's Care Center requires one morning per week in the outpatient Obstetrics Department and Delivery Room Coverage in four person rotation.

For information call Dr. Albert Tama at 609-424-5555.

ASSISTANT TO
DIRECTOR
OF BURN UNIT

Only certified burn facility in New Jersey offers one-year salaried position to board eligible general surgeon, emphasizing critical care. Traineeship in burn care provided. Academic atmosphere, with teaching of surgical residents, medical students and nurses. Career opportunity as a burn surgeon at this facility optional. Commence with salary plus benefits. Telephone or write to:

Frederick W. Fuller, M.D., Director
Burn Treatment Unit
Saint Barnabas Medical Center
Livingston, N.J. 07039
Telephone (201) 533-5928

RESIDENCY IN
PHYSICAL MEDICINE
AND REHABILITATION

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$16,100 to \$18,400 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

CLASSIFIED ADVERTISEMENTS

ORTHOPEDIC SURGEON—Board certified. 20 years solo practice. Desires lighter work load and better hours. Extensive general orthopedic experience as well as legal, industrial and academic experience. Write Box No. 252, c/o JOURNAL MSNJ.

PHYSICIAN—GP, desires fulltime office or clinic practice. Call M.D. at (504) 272-9726 in evening or write Box No. 242, c/o JOURNAL MSNJ.

RADIOLOGIST—Fully trained radiologist is available for parttime or vacation coverage. Box No. 240, c/o JOURNAL MSNJ.

UROLOGIST—Board eligible, desires group, partnership, solo, any type practice. Available immediately. T. Firoozi, (516) 221-7592 or (516) 825-8800.

NEEDED—OB-GYN—To join solo practice in South Jersey Shore Area. Growing area one hour from Philadelphia. Write Box No. 250, c/o JOURNAL MSNJ.

NEEDED—PHYSICIAN—Industrial clinic, Elizabeth, New Jersey. Previous surgical or ER experience required. Parttime or fulltime. Days only. Call (201) 467-0522 after 7 p.m.

DERMATOLOGIST—Wishes to buy active practice in New Jersey preferably within 30 minutes NYC. Would also consider position in medical group. Board certified, university affiliated, excellent references. Write Box No. 249, c/o JOURNAL MSNJ.

LOCUM TENENS—Parttime work wanted. Internist with gastroenterology training and ER moonlighting experience. Available July-September '81. Box No. 254, c/o JOURNAL MSNJ.

HOME/OFFICE—For Sale. Ventnor, N.J. Magnificent corner house, 2 blocks from ocean. Separate entry for office, newly decorated. No practice for sale. Excellent location or any professional. Call (609) 823-9376.

INFORMATION FOR MEMBERS—RATES—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT**: Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JOURNAL MSNJ" as six words. **COPY DEADLINE**: Fifth of preceding month.

RESIDENCE/OFFICE—For Sale. Spacious office-residence and office furnishings for sale of recently deceased GP. Small town location in a rural but developing area of northwestern New Jersey. Excellent opportunity for young family practitioner or internist. Call (201) 689-1705.

MEDICAL OFFICE—For Sale. South Jersey. 2 apartments building in doctor-shortage area. Close to Philadelphia. Phone (609) 467-0466 or write Mrs. S. Lintz, Box 157, Swedesboro, N.J. 08085.

PRACTICE FOR SALE—Union County, thriving, established general medical practice. Will introduce and advise. Building also available with rental property. Close to hospitals and medical centers. Please call after 7 p.m. only (201) 654-5974, (201) 654-6706 or write and send C.V. to Box No. 256, c/o JOURNAL MSNJ.

GENERAL MEDICAL PRACTICE—Vineland, NJ. Approximately 750 active patient files. Grossed approximately \$100,000, in 1980. Call between 9 a.m. and 5 p.m. (609) 691-1200. M. Kutner.

TAX SHELTER, Union City, N.J. 8 units, excellent location. Owner will assist financing. Priced right at \$120,000. Call 947-4333 after 7 p.m., 278-1000 1-6 p.m.

OFFICE SPACE—Edison. New Modern Professional Building. Will divide. Need all specialties. Onsite parking, near all major highways and hospitals. Call Dr. M. Bronstein (201) 826-5606.

OFFICE SPACE—Englewood. 1200 feet. Can be divided. Ideal for psychiatrists and surgical specialties. Two blocks from Englewood Hospital. Ample parking. Call (201) 568-1441.

OFFICE SPACE—TO SHARE—Linwood, near Atlantic City. Office space to share with internist. 800 square feet, new office, modern building offstreet parking, convenient location. Write Box No. 251, c/o JOURNAL MSNJ.

OFFICE SPACE—Livingston. For rent in medical office conveniently located in Livingston. Call afternoons (201) 994-3200.

OFFICE SPACE—SUBLET—Lawrenceville. Office completely furnished to sublet three days a week or evenings. Tuesday, Thursdays and Saturdays. Call evenings after 6 p.m. 896-0764.

OFFICE SPACE—RENT—Lincoln Park. Part/Full Time. Excellent location, near major highway. Call (201) 694-6260.

OFFICE SPACE—Livingston. Completely furnished, beautiful large office very close to St. Barnabas Hospital Livingston. Parking lot. Full or part time. Write Box No. 255, c/o JOURNAL MSNJ.

OFFICE SPACE TO SHARE—Elizabeth. Large suite in modern professional building, centrally located, ample parking. Common waiting room and own three rooms. Call (201) 289-0250.

OFFICE SPACE—RENT—Morris County. Opportunity to earn immediately with no financial investment. Time sharing rental of quality family practice office. Available also is rental of adjacent 900 square feet, one-bedroom apartment. Call (201) 328-1855. If you hear a beep after 2 rings, give your phone # 3 times and I'll call you back shortly.

OFFICE SPACE—Morris-Passaic County. Available in an oversize medical office, newly decorated. Excellent location in Morris-Passaic County, near all major highways, 30 minutes to NYC. Phone (201) 337-1627 evenings.

OFFICE SPACE—Roxbury Twp., Morris County. Prime location on Rt. 10 Tenants include large pediatric group, lawyer, architect, realtor. One 1356 square foot suite available. \$10/sq. ft. including all utilities, two smaller offices on lower level at \$7/sq. ft. Ideal office for dentist, podiatrist, ob-gyn, ent, etc. Air conditioning, carpeting, ample parking, easy access, storage available. Dr. Elliot Milgram (201) 584-9390.

ALAPULCO, MEXICO—Efficiency apartment directly on beach. Finest location. Kitchenette. Sleeps four. Balcony. Pool. Rent now by week or month for choice periods. (201) 992-3556.

POSTGRADUATE COURSE FOR PHYSICIANS

Recent Advances in Internal Medicine and Therapeutics

Twenty-Sixth Series

Sponsored by The Academy of Medicine of New Jersey and New Jersey State and Middlesex County Chapters of the New Jersey Academy of Family Physicians, Middlesex General Hospital and Rutgers Medical School

Meeting Place: Auditorium of Roosevelt Hospital, Menlo Park, New Jersey

Date: Wednesdays, 9 to 11 a.m., starting September 30, 1981 and ending May 26, 1982.

Beginning this September and ending May 26, 1982 the Postgraduate Course, "Recent Advances in Internal Medicine and Therapeutics," will be given as in previous years by Middlesex General Hospital of New Brunswick. However during 1981-1982 the lectures will be held in the auditorium of the new West Wing of Roosevelt Hospital, Menlo Park, New Jersey, pending completion of construction at Middlesex General Hospital.

As in previous years the 26th year of the Course is designed to present clear, concise reviews of important advances in internal medicine of interest to family physicians and internists in active practice.

The 1981-1982 series will be devoted to discussions of Cardiac and Pulmonary Disease, Arthritis, Nutrition, Neuropsychiatric Disorders, Cancer, Gastrointestinal Disorders, Treatment of Pain, Geriatric Medicine and many other subjects. Printed lecture notes are given out after each of the sessions.

IF YOU ARE INTERESTED IN ENROLLING AND HAVE NOT RECEIVED AN APPLICATION FORM IT IS IMPORTANT THAT YOU WRITE OR PHONE IMMEDIATELY TO THE CHAIRMAN OF THE COURSE AT THE DEPARTMENT OF MEDICAL EDUCATION, MIDDLESEX GENERAL HOSPITAL, 180 SOMERSET STREET, NEW BRUNSWICK, NEW JERSEY 08903; (201) 828-3000, EXTENSION 414.

The fee for the entire Course (34 sessions) is \$300. For interns and residents \$75.

The opening session is set for Wednesday, September 30, 1981.

August 1981

Journal of
the Medical
Society of

New Jersey

Neck Injuries in Football
Players

H. H. Sherk, M.D.

W. C. Watters, M.D.

Preparticipation Evaluation
for School Athletic Programs

P. J. Hirsch, M.D., et al.

Cimetidine: Use, Abuse and
Overuse

G. A. Marin, M.D.

*Complete Table of
Contents on page 568*

LIBRARY
U.C. SAN FRANCISCO

AUG 8 7 1981

The Library
Acquisitions Division
Univ. of Calif., San Francisco
San Francisco, Calif. 94143 S

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

***Check this list
against your
coverages***

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$7,500 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____

SPECIFY
ZYLOPRIM[®]
(allopurinol)
THE
ORIGINAL
ALLOPURINOL



Two convenient dosage forms:
100 mg (white) and 300 mg (peach)
Scored Tablets



Tablets imprinted with brand name to
assist in tablet identification.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



August 1981

Officers and Trustees

PRESIDENT	Armando F. Goracci, M.D. (Gloucester)	Woodbury
PRESIDENT-ELECT	Howard D. Slobodien, M.D. (Middlesex)	Perth Amboy
FIRST VICE-PRESIDENT	Alexander D. Kovacs, M.D. (Union)	Scotch Plains
SECOND VICE-PRESIDENT	Frank Y. Watson, M.D. (Essex)	Montclair
IMMEDIATE PAST-PRESIDENT	Augustus L. Baker, Jr., M.D. (Morris)	Dover
SECRETARY	Arthur Bernstein, M.D. (Essex)	East Orange
TREASURER	Rudolph C. Gering, M.D. (Mercer)	Pennington

Trustees

CHAIRMAN	
William Greifinger, M.D. (1984) (Essex)	Belleville
Meyer L. Abrams, M.D. (1982) (Burlington)	Cherry Hill
Frank Campo, M.D. (1984) (Mercer)	Trenton
Douglas M. Costabile, M.D. (1984) (Union)	Murray Hill
John J. Crosby, Jr., M.D. (1984) (Hudson)	Jersey City
Anthony P. DeSpirito, M.D. (1982) (Monmouth)	Neptune City
Ralph J. Fioretti, M.D. (1983) (Bergen)	Rochelle Park
Palma E. Formica, M.D. (1984) (Middlesex)	Old Bridge
Harry W. Fullerton, Jr., M.D. (1982) (Salem)	Carney's Point
Sherman Garrison, M.D. (1983) (Cumberland)	Bridgeton
John P. Kengeter, M.D. (1984) (Ocean)	Toms River
Myles C. Morrison, Jr., M.D. (1982) (Morris)	Morristown
Michael R. Ramundo, M.D. (1984) (Passaic)	Clifton
Bernard Robins, M.D., (1983) (Essex)	Springfield

Councilors

FIRST DISTRICT	(Essex, Morris, Union, and Warren Counties)	
Edward M. Coe, M.D. (1984)	.....	Cranford
SECOND DISTRICT	(Bergen, Hudson, Passaic, and Sussex Counties)	
Robert A. Weinstein, M.D. (1983)	.....	Newton
THIRD DISTRICT	(Hunterdon, Mercer, Middlesex, and Somerset Counties)	
Albert F. Moriconi, M.D. (1982)	.....	Trenton
FOURTH DISTRICT	(Burlington, Camden, Monmouth, and Ocean Counties)	
Frederick W. Durham, M.D. (1984)	.....	Haddonfield
FIFTH DISTRICT	(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)	
Ronald M. Fisher, M.D. (1983)	.....	Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982)	Hackensack
William J. D'Elia, M.D. (1981)	Spring Lake
Frederick W. Durham, M.D. (1982)	Haddonfield
Karl T. Franzoni, M.D. (1982)	Trenton
John S. Madara, M.D. (1982)	Salem
Henry J. Mineur, M.D. (1982)	Cranford
Myles C. Morrison (1981)	Morristown

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Julio C. del Castillo, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

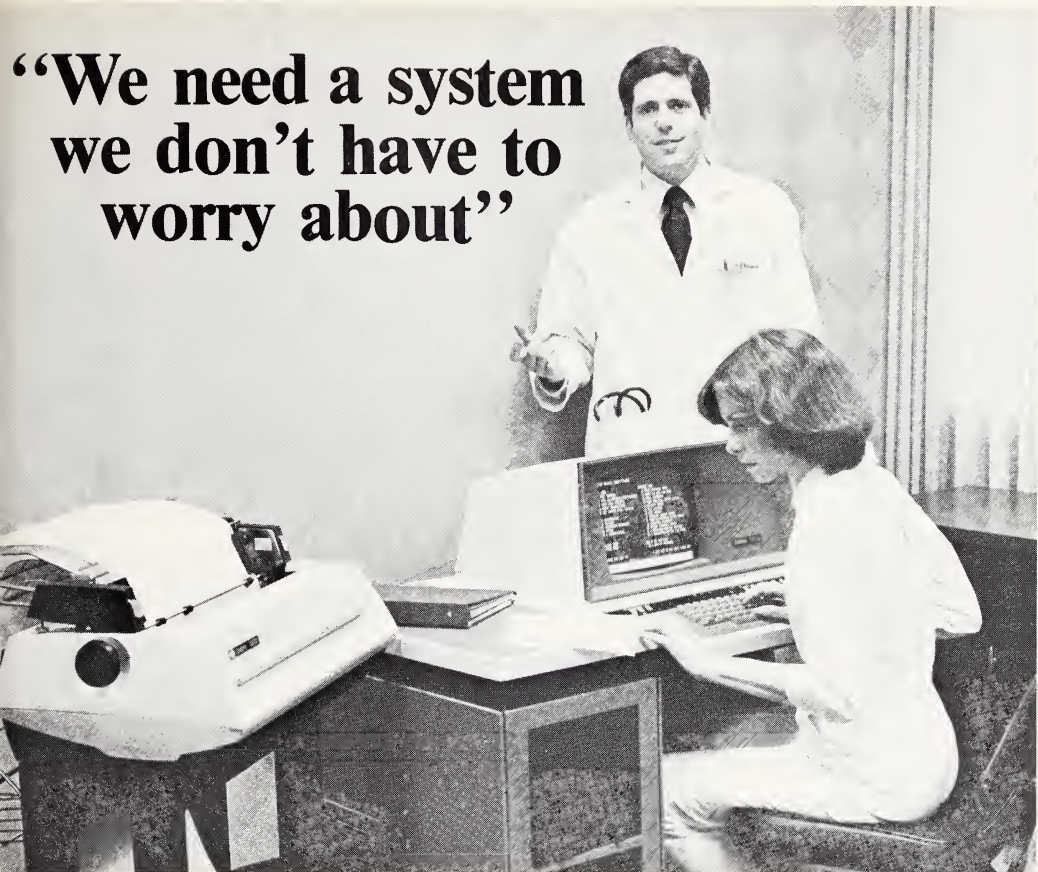
Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.
Harold Arlen, M.D.
Alfonse Cinotti, M.D.
Stuart D. Cook, M.D.
Robert Dodelson, M.D.
Wm. A. Dwyer, Jr., M.D.
Norman H. Ertel, M.D.
A. Olusegun Fayemi, M.D.
Arthur Goldfarb, M.D.
Robert A. Goldstone, M.D.
Murray Kahn, M.D.
Monroe S. Karetzky, M.D.
Avrum L. Katcher, M.D.
Sidney Ketyer, M.D.
Bernard J. Koven, M.D.
Joel D. Levinson, M.D.
Henry R. Liss, M.D.
Robert M. MacMillan, M.D.
Geobel A. Marin, M.D.
Murray Nussbaum, M.D.
Christopher M. Papa, M.D.
Victor Parsonnet, M.D.
Irwin Pollack, M.D.
Bernard A. Rineberg, M.D.
Edwin L. Rothfeld, M.D.
Benjamin F. Rush, Jr., M.D.
Morris H. Saffron, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Sheldon D. Solomon, M.D.
Lloyd N. Spindell, M.D.
A. Arthur Sugerman, M.D.
Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess R Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 928. Meml subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single co \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

"We need a system we don't have to worry about"



Dr. I. David Weisband, of the Regional Orthopedic Professional Association, is one of a growing number of physicians who've found Minicom's Medical Practice Management System meets the unique needs of a medical practice.

Automatic preparation of statements, Medicare and insurance company forms; instantaneous, up-to-the-minute accounts receivable information, plus a variety of practice analysis reports.

"We treat patients, not computers," Dr. Weisband says, "so we need a system we don't have to worry about."

And our Medical Practice Management System is just that. It

features reliable Xerox Diablo equipment and is backed by our policy of Unsurpassed Service—hardware, software, training, maintenance and system back-up, all from one reliable source.

"Our office manager and accounting firm investigated alternatives," he continues, "and recommended the Minicom system as the best solution to our needs. I agree."

So, before you invest in a computer system for your practice, take his advice. Look into our Medical Practice Management System. Drop the coupon in the mail, or give us a call...and ask about US!

I'd like more information on Minicom's Medical Practice Management System.

Name

Address

City, State, Zip

Telephone (Area Code)

MNJ



MINICOM

1415 E. Marlton Pike,
Cherry Hill, N.J. 08034
(609) 429-0600
(215) 925-6908

UNSURPASSED SERVICE

Distributors of Xerox business and professional computer systems.

Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

573 **PROFESSIONAL LIABILITY COMMENTARY**

EDITORIAL

577 What Your Patients Are Reading: DRG

ARTICLES

579 Neck Injuries in Football Players

H. H. Sherk, M.D.; W. C. Watters, M.D., Camden

585 Preparticipation Evaluation for School Athletic Programs

P. J. Hirsch, M.D.; S. A. Hirsch, M.D.; L. Reedman, C.M.A.; B. A. Rineberg, M.D.; A. B. Weiss, M.D., Newark

591 Chemical Fire at Toxic Waste Disposal Plant: Epidemiologic Study of Exposure to Smoke and Fumes

W. Halperin, M.D.; P. J. Landrigan, M.D.; R. Altman, M.D.; A. W. Iaci, M.S.; D. L. Morse, M.D.; L. L. Needham, Ph.D.

STATE OF THE ART

595 Cimetidine: Use, Abuse and Overuse

Geobel A. Marin, M.D., Trenton

CASE REPORTS

598 Infant with Streptococcus Bovis Meningitis

J. L. Murillo, M.D.; J. A. Titelbaum, M.D.; J. Martinez, Newark

600 Carcinoma Arising Out of a Primary Acquired Cholesteatoma

S. T. Westerman, M.D., Shrewsbury; L. C. Sylvia, M.D.; E. Tepper, M.D., Long Branch

COMMENTARY

603 Middle-Age Crisis: A Preventive Approach

Arnaldo Apolito, M.D., Montclair

MEDICAL HISTORY

606 Notes on a Bygone Practice in a North African Country

Aldo A. Calo, M.D., Princeton

611 **NUTRITION UPDATE**

DOCTORS' NOTEBOOK

614 Trustees' Minutes: May 19, 1981

616 CMDNJ Notes

617 DESAD Project

617 Physicians Seeking Location in New Jersey

620 **LETTERS TO THE JOURNAL**

622 **PERSONAL ITEMS**

623 **CME CALENDAR**

626 **OBITUARIES**

628 **BOOK REVIEWS**

Cover

The cover is an original drawing by Elizabeth Ruggles, a well-known teacher and artist in the Trenton area, formerly on the staff of the New Jersey State Department of Health.



You're Invited to Tour Our Facilities

The majority of physicians have never toured a modern rehabilitation hospital, and because of this we're extending an open invitation.

New Jersey Rehabilitation Hospital, located by Exit 145 of the Garden State Parkway, is a specialty hospital which treats catastrophic injuries to spinal cord and brain, stroke, quadriplegic, paraplegia, loss of limb, musculo-skeletal injuries, neck and low back injuries, and other mental and physical impairments, often resulting from automobile or work accidents.

To arrange for an escorted tour of our facilities, call Bucky Harris, at (201) 673-1860. We believe you'll be impressed with modern rehabilitation medicine.



New Jersey Rehabilitation Hospital

Owned and operated by Moderncare Centers of America, Inc.

240 Central Avenue, East Orange, NJ 07018 • 201-673-1860

Bertrand J. Bensam, MD, Medical Director • Stanley Shepard, Administrator

Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities and the American Board for Certification in Orthotics and Prosthetics Inc.

Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white glossy

prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

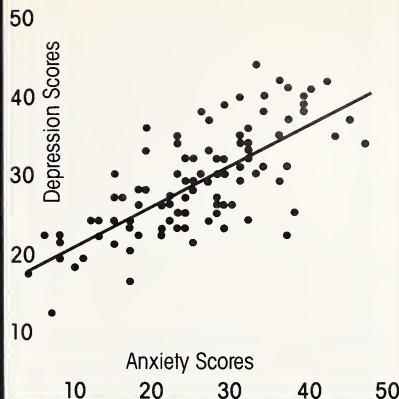
REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.

The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scales in 100 nonpsychotic psychiatric patients. The coefficient of correlation is 0.7. As depression increased, so did the anxiety levels.¹



WHY MORE PHYSICIANS ARE CHOOSING LIMBITROL

It fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician¹ found a correlation of 0.7 in anxiety and depression scores; another² has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

It is more appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression. These contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.^{2,3}

It avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Claghorn J. *Psychosomatics* 11: 38-441, Sept-Oct 1970. 2. Rickels K. Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. 3. Baldessarini RJ, Torsy D. Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress*, edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p. 999.

in moderate to severe depression and anxiety

Limbitrol[®] ^{IV}

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

because it's specific for anxious depression in the nonpsychotic patient



Please see summary of complete product information on following page.

LIMBITROL® TABLETS (m) Tranquilizer — Antidepressant
Before prescribing, please consult complete product information,
a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlorhidazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlorhidazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.

In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely. The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.


Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdose: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlorhidazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlorhidazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500. Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Packs of 50.

 **ROCHE** ROCHE PRODUCTS INC.
Mantol, Puerto Rico 00701

REDWOOD DECKS

Call Mike

The Fancy Deck Builder

(201) 595-6263

NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

Professional Liability Commentary*

Featuring: New York Malpractice Rate Crisis . . . Will It Spread To New Jersey?

The following item was prepared by Peter Sweetland, President, New Jersey State Medical Underwriters, Inc.

Any physician who follows the published results of professional liability insurance companies has been confused in the past by varying claims as to whether or not the "malpractice crisis" has been solved. There even have been frequent assertions that it never existed. Now, with the two major insurers in New York indicating that tremendous rate increases are needed, the confusion has turned to dismay and increasing anxiety. This April, the Medical Liability Mutual (New York's doctor-sponsored carrier) filed for a 71 percent increase, and also stated that right now it looks as though at least another 40 percent will be needed in 1982. Ten days later, the Medical Malpractice Insurance Association (the state's Joint Underwriting Association) sought 367.8 percent more than their present rates. In making these requests, principals indicated that they are projecting future claims payouts averaging more than \$100,000 apiece. Do we see this same thing happening in New Jersey? If not, what is so different here?

By the time this commentary is published, we expect the New York Superintendent of Insurance will have made some decision as to the appropriateness of each filing. Past experience shows that the Department has greatly depressed or flatly rejected increases of these dimensions and it is hard to conclude that they will survive this time on an unmodified basis. Most of you also may be aware that the Medical Society of New York has mounted an extensive effort to produce legislative reform which might moderate those perceived loss patterns which lead to the dramatic increase requests. Recent releases identify average claim costs thus far in 1981 well into the six-figure range. We are aware of at least one New York judgment a month, so far this year, in excess of a million dollars. Two cases in May alone were awarded \$5 million and \$2 million respectively.

You often have heard that rate making in professional liability is based upon many uncertainties. The primary approach simply projects current averages of paid losses and number of cases per insured doctor to some eventual value, after applying trend factors, which also are developed from past experience. Whenever a series of large awards or settlements surface, greatly exceeding past expectations, the old factors are adjusted and the impact on ultimate projections can be substantial. We have not reviewed New York's rate filing in any detail, but it is safe to conclude that such a dramatic change in results, coupled with a change in actuaries, has produced this extreme increase. It is impossible to forecast accurately whether or not this changed pattern truly does foretell greatly altered final results, but it is difficult for any company leadership to ignore such signals and continue to call themselves fiscally responsible.

In New Jersey, we do have some slightly different conditions. First, average loss values are going up at an inflationary pace, but we have not seen the dramatic change

encountered in New York. We feel that this is partly the result of a difference in claims management philosophy. In any claim (particularly those with high damage value) where peer review has established that the circumstances are medically indefensible, we have sought to settle promptly. As a result, our early average paid value was higher than in other states. But now, after four years, we see everyone else exceeding or surpassing our averages. Time and again, we have seen proof that the difficult case winds up worth more in court than in prior negotiation. We also have been to court on a number of cases which we considered defensible, and there our experience is varied. So far, on a very small number of trials, we have lost approximately one-half. Fortunately, these have not been high value cases, and the impact on our averages has been negligible. One-third of all cases peer reviewed are found to be defensible, and we sit today with many of them awaiting panel review and subsequent trial. We believe that prompt disposition of the deserving cases has freed us to devote more energy to those in which we are certain our insureds are not at fault. We expect that you may read, in the future, of occasional big judgments against us in court in the same manner that New York has received press of late. We do feel, however, that they will be much more infrequent, and the ultimate impact on average loss values nowhere near as dramatic.

Another area of distinction is the relative size of policyholders' surplus in the two states. An adequate surplus can function as a good cushion in the event that temporary indications might call for higher rates. The average surplus contribution by New Jersey physicians was roughly three times as much as the charges made in New York. There may have been a savings initially for New York physicians, but it appears now that they have less to fall back on while they wait to see whether new severity indicators are real. Here in New Jersey we were able to augment the value of our surplus with additional earnings from investment. These funds were available to increase reserves without a dramatic change in rates. We are constantly reappraising the value of our individual reserves and the appropriateness of our rates, but we have not seen sufficient indications of major change to warrant any reconsideration of past decisions.

As you know, we did file for a 9.7 percent rate increase for this year. To date, the New Jersey Department of Insurance has not acted on the request. We do expect there will be continued inflationary pressure on loss costs, and until we can have a measurable impact from loss prevention programs, periodic rate changes of this size will be appropriate. If the Insurance Department continues to postpone our ability to make needed small changes, the deficiency will compound.

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

At this point, it is still difficult to conclude that any malpractice situation has changed as dramatically as the New York experience indicates. Most other doctor-owned carriers across the country have been seeking rate increases over the last year, but for the most part, they have ranged from 10 to 25 percent. You can be sure that the physician leadership of the Medical Inter-Insurance Exchange of New Jersey has not ignored the goings-on across the Hudson; but at this point they need an entirely new set of changed results to reach the same drastic conclusions.

DID YOU KNOW

... Most patients don't mind waiting up to half an hour, a recently released Health and Human Services' survey reports. But 40 percent get dissatisfied when the wait approaches an hour. It seems doctors are pushing patient's good humor to the limit. The average time spent waiting to

see the doctor is 29 minutes. . . *Medical Economics*, 5/25/81.

... In June, the Health Care Insurance Exchange (HCIE) reported it was writing claims made coverage for 1400 New Jersey physicians. This is an increase of 520 physicians since their expansion of coverage to non-hospital staff physicians.

MEDICOLEGAL SEMINARS AT ANNUAL MEETING

The Department of Professional Liability Control presented two medicolegal seminars for three medical specialties at the Medical Society of New Jersey's 1981 Annual Meeting.

The New Jersey State Society of Anesthesiologists and the New Jersey Obstetrical and Gynecological Society jointly presented a seminar entitled, "Anesthesia in Obstetrics—Is There Room for Change?" The Orthopaedic Society of New Jersey's program was entitled, "The Orthopaedic Surgeon and Malpractice." Both seminars were well attended with active audience participation.



The New Jersey Society of Anesthesiologists and the New Jersey Obstetrical and Gynecological Society Medicolegal Seminar. James E. George, M.D., J.D., Joseph Cox, M.D., Robert Widows, M.D., Daniel Colombi, M.D., and Courtney Malcarney, M.D.



James E. George, M.D., J.D. and Bernard Genest, Vice President of Claims at the Medical Inter-Insurance Exchange of New Jersey answer a question posed by Arne Skilbred, M.D., during the Orthopaedic Society's Medicolegal Seminar.

At 4:25 PM mild mannered Sheryl DePaul made a harried doctor smile.

Sheryl is part of our special Blue Shield professional relations staff. Sheryl and her colleagues specialize in answering physicians' questions. You can depend on our professional relations staff for quick answers to your questions regarding claims, billing information, and contract interpretation.

In addition, professional relations staff members handle the enrollment of new participating physicians, and the training of medical assistants.

So, next time you run into a Blue Shield related problem, call on us for the answer.



*"It's our job to
make things simple."*



Blue Shield of New Jersey

An added complication... in the treatment of bacterial bronchitis*

Increasing incidence
of ampicillin resistance in
Haemophilus influenzae

Ampicillin Resistant
Haemophilus influenzae

H. influenzae

S. pneumoniae

Brief Summary Consult the package literature for prescribing information

Indications and Usage: Cefclor* (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococcus). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS. CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARALLEL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose of 10 tablets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Lactation: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.^{1,4}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococcus), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®
cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefclor therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 30).

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic:—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic:—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal:—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor* (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother. 8: 91, 1975.
2. Antimicrob. Agents Chemother. 11: 470, 1977.
3. Antimicrob. Agents Chemother. 13: 584, 1978.
4. Antimicrob. Agents Chemother. 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthal and R. Luthy), II, 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother. 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Lilly
100061

Additional information available to the physician on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00930.

What Your Patients Are Reading: DRG

During the 215th Annual Meeting of the Medical Society of New Jersey, the House of Delegates passed two resolutions dealing with the Diagnosis Related Groups (DRGs) concept of hospital reimbursement. Each was negative, i.e., expressed the Society's opposition to DRGs per se on a conceptual basis and pledged to provide information to the Legislature with the presumed end result of legislative intervention aimed at dissolution of the program.

When your patient is admitted to a New Jersey hospital which is a participant in the DRG program, he will be given a pamphlet entitled "DRG: A New Way To Pay for Hospital Care." Each physician at least should be aware of the content of this brochure and should be prepared to answer questions or discuss the meaning of DRG with his patients.

The material included is as follows:

"We're Working for Your Rapid Recovery

"While you're a patient here, you'll be receiving the finest care we can provide. Our physicians, our nurses and our entire staff are committed to your rapid recovery with minimum inconvenience to you and your family.

"During your stay, you'll probably hear a lot of terms new to you. Although they may be unfamiliar, each word, or phrase, or set of initials has special meaning to the professionals in charge of your care.

"One of the newest terms in the hospital dictionary is Diagnosis Related Groups—DRGs for short—which represent a new method of paying for the care and services you receive while you're a patient here.

"We're required by law to participate in the DRG payment program at the direction of the New Jersey Department of Health. And we must charge what we are told by the New Jersey Hospital Rate Setting Commission.

"Because the program is complex, it can be confusing. We've prepared this brochure to help you understand how you will be charged for the care you receive."

"Different Illnesses, Different Payment Rates

"Regardless of why you're here, it should be comforting to know you're not alone. In dozens of hospitals throughout New Jersey, hundreds of patients are recovering from the same illness or injury which brought you to our hospital.

"The similarity between certain illnesses and injuries, in fact, is the basis on which the State Department of Health has built the DRG program.

"By dividing all illnesses and injuries into 383 groups (DRGs) the State has established separate categories for heart attacks, broken bones, appendicitis, pneumonia, diabetes and many other forms of illness and injury.

"The State also decides how much our hospital will be

paid for your care and treatment. They've established a separate rate for each DRG category and will allow us to charge no more—nor less—than the amount they determine to be appropriate. Your bill, for example, will reflect a DRG payment rate determined by the State on the basis of information provided by your doctor."

"What To Look for on Your Bill

"The payment rate for your care and treatment is based on the *average* cost of services required for *all* patients in your DRG category.

"While your rate covers the cost of your hospital care, it does not include such personal items as television and telephone, or the professional services of your private physician.

"Your hospital bill, therefore will show the DRG payment rate set by the State.

"Charges for personal services, such as telephone and television, will be your responsibility.

"If your hospital stay is longer than the average patient in your DRG group, the cost of your care may be greater than the DRG rate set by the State. If, on the other hand, your stay is shorter than the average patient in your group, the cost of your care may be less than the DRG rate.

"The DRG rate established by the New Jersey Hospital Rate Setting Commission will apply to most patients. The remainder—for example, those with unusual lengths of stay—pay charges approved by the Commission rather than the DRG rate."

"How Will Your Bill Be Paid?

"If your hospital stay is fully covered, your insurance company, Medicare or Medicaid will pay the bill.

"If you are not fully covered, a portion of the bill will be paid by you. Persons without any insurance pay the entire bill.

"The cost for which you are responsible can be reduced by prompt payment. These discounts will be explained in detail when you receive your bill.

"With a few more details than we have room to list, that's how the DRG payment plan works. Because it's so new, there still may be questions for which no one has the answer.

"If you're concerned about how your bill is calculated, we'll try to help.

"In short, when the time comes to consider the cost of your care, we'll do everything we can to help. In the meantime, all of us will be working to make your stay pleasant, your recovery rapid, and your future healthy."

The leaflet was prepared by the New Jersey Hospital Association, which also has expressed opposition to the

DRG program. Benign as the material may read, the leaflet hits home at several critical points, which may or may not be recognized by a casual perusal:

—Hospitals are required by law to participate in the program, i.e., it is not voluntary.

—The New Jersey State Department of Health is the director of the program—not the New Jersey Hospital Association or MSNJ.

—Hospitals are reimbursed according to charges decided by the New Jersey Hospital Rate Setting Commission—a government agency. These rates are not based on the literal cost of the patient's stay in the hospital, which can be calculated quite as accurately as any service agency can determine its cost, but on complex, nonscientific guesstimates.

—The similarity between some 383 groups of illnesses and injuries is the basis for computation. The individuality of patients—a fact which is foremost in the minds of all physicians—is not considered.

—The state determines the rate to be paid—no matter who the payer may be—and the hospital must charge neither more nor less than this amount. The payment rate is based on the average cost of services required by all patients in a DRG category—a concept which will prove to be akin to the "no frills, box-lunch" airlift which is being offered by some airlines.

—The hospital stands to make money, i.e., profit by hospital stays which are shorter than the average patient in a group, but will lose money on patients whose hospital stay is longer than the average. This, of necessity places the hospital business manager and the physician and his patient in an adversary relationship.

The President of MSNJ, Armando F. Goracci, in his inaugural address commented on DRGs. He emphasized the experimental nature of the program and warned that its

complexity cannot permit categories and rates to be set in concrete, for the fluid and progressive nature of medical diagnosis and treatment and scientific knowledge mean an ever-changing milieu which will not hold still for simplistic solutions. Any lag on the part of the Hospital Rate Setting Commission is most likely to work to the detriment of the hospital and, unfortunately, the track record of government rate setting agencies, as exemplified by Medicaid reimbursement, should give nightmares to hospital business managers.

Dr. Goracci pointed out that although DRG is a fact of life, a fait accompli, according to the New Jersey State Commissioners of Health, in reality it remains an experiment in health economics whose merits and demerits still are to be determined. He rightly invoked the fact that the presumptive behavioral and attitudinal changes on the parts of physicians and patients on which the State hinges its hopes for success are not likely to occur:

"The Department of Health presumes that hospital administrators can change a doctor's practice pattern to comply with the DRG payment standards. Doctors strongly question attempts to standardize medical practice and they repudiate the notion of averages, focusing instead on the medical needs of the individual patient. Furthermore, informed patients will object to their physicians functioning as 'efficiency experts' in matters pertaining to their health."*

Dr. Goracci concluded that "the present problems inherent in the DRG reimbursement system preclude any possibility of its successful implementation in New Jersey."

Since MSNJ clearly has expressed its opposition to DRG through its House of Delegates and mandated a program of opposition by way of the State Legislature, it behooves every physician, whether his hospital is on DRG or not, to be conversant with the program and to explain it to his patients before, during or after their occupancy of a hospital bed.

A.K.

*Goracci AF: Partnership, Not Domination. *J Med Soc NJ* 78:435-437, June 1981.

Neck Injuries in Football Players*

HENRY H. SHERK, M.D. and
WILLIAM C. WATTERS, M.D., Camden

Because of the widespread use of hard-shell plastic helmets and face guards, neck injuries in football have increased relative to head injuries. Forces impacting on the head are transmitted to the cervical vertebra causing fractures and/or dislocations with or without spinal cord or nerve root injury. Short of abolishing football, prevention requires special equipment, good conditioning and safety rules enforced by coaches and referees.

Tackle football with its emphasis on collision and impact has evolved into a sport which has the potential for producing severe injuries of the cervical spine. Recent reports have recorded large numbers of such cases documenting the increased risk assumed by those who engage in it (Table I). In the past most severe or fatal injuries in football involved cerebral trauma. Now almost universal use of hard-shell plastic helmets and double-bar face guards afford players very effective protection of the face and cranium. With the feeling of security that they will not sustain a facial or head injury, players now tend to use the head as a weapon for butting, blocking or spearing. Forces which previously caused damage to the face and head are now more likely to be transmitted down to the neck causing fractures and/or dislocations of the cervical vertebrae.^{2,5,8}

The purpose of this paper is to focus attention on one of the major social costs of a popular sport, to point out ways in which youthful athletes can sustain catastrophic injury, and to note how the injuries can be treated and prevented.

OCIPITO-CERVICAL AND CERVICO-MEDULLARY TRAUMA

Hyperextension of the head on a relatively fixed cervical spine can compress or even crush the vertebral arteries as they loop upward over the atlas vertebra to enter the skull. The resultant vascular insufficiency of the vertebrobasilar arterial system typically produces vertigo, blurring of vision, nausea, dysarthria, vomiting and other symptoms associated

with the Wallenberg syndrome. Violent impact on the head in this type of injury also causes disparate distortion between the freely moving brain and the relatively fixed cervical cord rigidly held by the investing spinal column and its musculature. Wave-like motion of the brain caused by the contrecoup phenomenon creates petechial hemorrhages in the upper spinal cord especially at the C2 level where a normal zone of poor collateral blood supply intensifies the subsequent changes.¹⁵

These patients may have significant vascular and neural injury without having sustained an identifiable fracture or dislocation of the upper cervical spine. Fractures of the atlas or axis may result from forcible hyperextension which pushes the posterior part of the rigid helmet backwards into the upper neck. Such leverage can fracture the odontoid process or rupture the transverse ligament of the atlas and cause atlanto-axial instability. Such injuries can occur independent of neurological or vertebral artery trauma but when present in players with the symptoms already described they should alert the physician to a potentially serious medullary and upper cervical cord lesion. Respiratory insufficiency in these patients suddenly may require ventilatory support before a complete neurological workup can be accomplished. After the neurosurgical emergency situation has stabilized, the patient may require orthopedic management of the fracture.

*From the Cooper Medical Center, Camden, where Dr. Sherk is chief of the department of orthopedic surgery and Dr. Watters is a staff member of that department. Correspondence may be addressed to Dr. Sherk at 2647 Westfield Ave., Camden, NJ 08105.

Table I
Incidence of Head and Neck Injuries
in Football Players

Albright ¹ - 1976	-	1. 32 percent of college freshman players had x-ray evidence of prior neck injury 2. 16 percent of high school players reported neck injuries
Blythe ⁴ - 1931-1976	-	873 deaths related to football nation-wide - 61 percent due to head injuries
Schneider ¹⁶ - 1959-1963	-	189 serious or fatal head injuries collected from members of Congress of Neurological Surgery
Torg et al ¹⁸ - 1971-1975	-	1. 1,129 major head and neck injuries in National Football Head and Neck Registry 2. 550 neck fractures and dislocations 3. 126 permanent quadriplegics

Upper cervical spine injuries and cervico-medullary lesions due to football probably should preclude a player from returning to the sport.

MID-CERVICAL FRACTURES AND DISLOCATIONS

Several reports^{3,10} have classified these lesions on the basis of the mechanism of injury noting that extension, flexion, impaction and rotation beyond physiologic limits permanently distort the normal neck anatomy in predictable ways. Flexion injuries produce forward displacement of a vertebra on the vertebra below it causing wedge compression fractures of a vertebral body or unilateral or bilateral facet dislocations. When the injury combines flexion with compression, the vertebral body may break into multiple fragments one of which may be retropulsed into the spinal canal. This "tear drop" fragment can compress the anterior spinal artery and the anterior portion of the spinal cord. Quadriplegia results from the anterior spinal artery syndrome causing permanent and catastrophic disability. Wedge compression fractures and facet dislocations may not produce neurologic injury as often but the risk of worsening the displacement of the cervical vertebra should make team physicians and trainers especially wary in transporting injured players. Careful splinting and holding of the head to prevent displacement of cervical vertebrae should be a top priority in handling these players injured on the field. Compression and extension injuries may produce pedicle fractures and avulsion of the anterior inferior margin of a vertebra. Pure extension injuries cause less obvious

roentgenographic changes. Patients with this type of injury may have normal films or manifest only a small fleck of bone avulsed from the anterior margin of a vertebra.

In recent years surgical decompression of the injured cord has found less favor than immediate reduction of displaced cervical vertebrae with traction and stabilization of the injured spine. While difference of opinion still exists regarding the role of laminectomy, most reports do indicate that documented, complete quadriplegia has a poor prognosis regardless of treatment. Prompt reduction and stabilization of displaced vertebrae with incomplete cord lesions offers the injured player more rapid relief of pain and prevents continued compression by the malaligned spinal elements.¹⁴ Players with severe neck injuries should not expose themselves to the risk of contact again after even the most successful treatment, since treatment usually requires fusion of one or more levels of the injured cervical spine. The remaining mobile segments must absorb greater stress than normal and failure of the spine may be expected.

BRACHIAL PLEXUS INJURIES

Several reports have described patients with the lateral pinch syndrome or "the burners," caused by stretching of the cervical spine laterally. A charging opponent strikes a blow on the side of the player's head turning it sharply laterally beyond its physiologic limits, usually fifty degrees in either direction.¹¹ The player experiences almost immediate pain from the base of the neck to the hand with prickly burning paresthesias extending down the arm. The player finds it difficult to move the entire arm shortly afterwards.

The clinical picture relates to the severity of injury. In mild cases the player has sustained an axonotmesis of the upper cord or the brachial plexus. In less severe cases patients will have no roentgenographic changes acutely, but later may develop vertebral body spurring consistent with osteoarthritis. Weeks later electromyography almost always reveals a pattern of axonal degeneration of the biceps, deltoid and supinators suggesting that the lesion is a stretch of the upper trunk of the brachial plexus. More severely involved players manifest profound weakness and numbness of the upper extremity and a Horner's syndrome. Myelography may show extravasation of contrast material. Patients with this degree of severity never recover strength in the extensors, supinators or flexor pronator muscles of the forearm.

There is no effective surgical treatment for these patients. In general, with physiotherapy they have a good prognosis and all but the most severely injured recover virtually completely. Prevention of the injury requires the use of high conventional shoulder pads to limit lateral motion of the head and cervical collars to prevent lateral bending of the neck.

"... extension, flexion, impaction and rotation beyond physiologic limits permanently distort the normal neck anatomy in predictable ways."

"... reports have described patients with the lateral pinch syndrome or "the burners," caused by stretching of the cervical spine laterally."

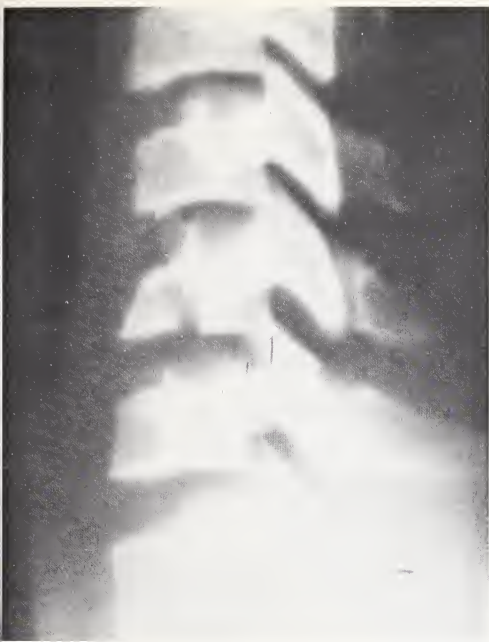


Figure 1, Case 1—Lateral roentgenogram showing bursting fracture of C3. This lesion produced permanent quadriplegia in a 17-year-old halfback.



Figure 3, Case 2—Lateral roentgenogram. Persistent instability required posterior fusion. Note changes in anterior superior border of C6 resulting from injury to the secondary vertebral epiphysis.



Figure 2, Case 2—Lateral roentgenogram showing bilateral facet subluxation of C5 on C6, resulting from football injury in a 13-year old boy.



Figure 4, Case 3—Lateral view of bursting fracture of C5 in 17-year-old football player rendered permanently quadriplegic by the injury.



Figure 5, Case 3—Lateral view showing immediate post-operative result of anterior fusion.



Figure 6, Case 3—Lateral view of neck showing extrusion of bone graft. Unstable cervical spines almost always should be fused posteriorly.

CASE REPORTS

Case 1—A 17-year-old boy on the kick-off on the first game of his high school senior year ran down field to tackle an opposing ball carrier. He made contact in a head-down spearing position. He felt a tearing neck pain and an intense burning sensation in all four limbs. Immediately thereafter he had no sensation in his entire body and could not move his arms or legs. X-rays revealed a bursting fracture of C5 (Figure 1) with retropulsion of bony fragments into the spinal canal. The patient had a complete quadriplegia at C5. Treatment with twenty pounds of skeletal traction reduced the malalignment but two years after injury he remains totally incapacitated.

Case 2—A 13-year-old boy sustained a C5-6 subluxation from head-down contact with an opponent followed by a multiplayer pile on. The patient experienced no neurological symptoms and had no signs of neurological deficit, but he had severe discomfort in the neck. X-ray examination showed a kyphus at the level of injury. Treatment with halter traction and prolonged support in a Philadelphia collar failed to relieve his complaints. Surgical fusion of C4-7 following open reduction of the fracture dislocation made him symptom free. (Figures 2, 3)

Case 3—A stocky 17-year-old high school offensive half-back made a head-down block. He experienced sudden neck pain and explosive paresthesias in the trunk and all four limbs. Examination revealed a C6 quadriplegia. X-rays showed a bursting fracture of C5 with some displacement on C6. Skull tong traction failed to change the quadriplegia. An anterior fusion for spine stability collapsed and the bone plug

extruded anteriorly. Satisfactory stabilization of the neck was finally achieved with a posterior fusion. Failure of the anterior fusion reemphasizes the need for reconstitution of the tension band of the spine as opposed to the compression side in anterior dislocations and fractures.¹⁴ (Figures 4, 5 and 6)

DISCUSSION

Prevention of major injuries to the cervical spine should be a serious concern of school boards, coaches, physicians and parents. Of course, the problem would disappear if schools abolished tackle football. This seems unrealistic at present so precautionary measures must be utilized.

Adequate player conditioning is absolutely essential. Players must have supervised muscle strengthening exercises and formal conditioning programs before being allowed to engage in contact. Athletes with long, thin, poorly muscled necks have a greater likelihood of sustaining neck injuries. Major neck injuries occur most often in early season practice games before players have been adequately hardened by exercise.⁵ Those schools who hire coaching staffs or have medical responsibility for the team have the obligation to ensure proper compliance with these requirements and must not permit poorly conditioned players to enter the hostile environment of the playing field.

Coaches must teach players to play safely, absolutely forbidding them to engage in spearing and butting tactics. Referees must enforce safety rules to keep players from injuring their cervical spines.

Coaches and school boards can lower the incidence of

neck injuries by making sure that athletic equipment is adequate and that it fits properly. The helmet is probably the most important piece of equipment in this regard since player's heads have been shown to absorb up to 230 G's in 350 milliseconds. Without a properly applied helmet suspension system, this degree of impact would cause brain damage documented by EEG changes which have been described in such players.¹¹

Finally, injured players must not be permitted to return to the game too soon. Concussions are still very common in football although the number of more serious head injuries has declined relative to neck injuries.¹² It is not uncommon to hear of players being rendered unconscious and then returning to the contest playing out a quarter or half with little or no later recollection of the events of the game. This practice is potentially hazardous, if it recurs.

Certainly any player with a history of documented major neck injury or an inflammatory or congenital cervical spine lesion would assume too much risk to be permitted to play. Patients with such lesions may develop spinal cord compression with minimal injury and they would assume too great a risk to be exposed to the hazards of violent contact regularly.

Poor coordination and delayed reflex control appear to be factors contributing to neck injury. Impact forces can be lowered to much safer levels by a player's split-second learned responses such as rolling on contact to change a direct force to a less dangerous glancing contact. The athlete should be in complete control of his postural responses and not have to rely on reflex activity.

SUMMARY

Tackle football causes a large number of head and neck injuries, some of which are fatal or associated with permanent catastrophic physical impairment such as quadriplegia. High cervical cord and brain stem lesions can occur without roentgenographic evidence of fracture when contusions of the vertebral artery at the C1 level cause thrombosis of the vertebro-basilar system. Fractures of the atlas and axis can occur independent of vertebral artery injury and these fractures should be managed by support and stabilization once neural and vascular damage has been ruled out or treated.

Mid-cervical spine fractures and dislocations are classified on the basis of the mechanism of injury. The most dangerous lesion appears to be that caused by flexion and impaction. This type of injury often results in a bursting fracture with retropulsion of disc and/or bony fragments into the spinal canal, compressing the cord. This lesion is the one most likely to cause quadriplegia. Reduction and maintenance of position by traction or halo support may be preferable to laminectomy which tends to destabilize the spine in young patients. Direct anterior decompression, may be achieved

with removal of fragments from the front of the spinal cord. In flexion injuries with persistent instability, posterior fusion probably will be required after reduction of the fracture to prevent recurrence of deformity.

Excessive lateral bending of the neck causes "the burners" associated with burning paresthesias down the arm and hand with weakness of the deltoid, biceps, and supinators. Stretch of the upper roots and cords of the brachial plexus produces these findings. When a Horner's syndrome accompanies "the burner," one or more roots probably has been avulsed. There is no special treatment for most cases of "the burners." Symptoms disappear spontaneously unless the roots have been avulsed.

The number of neck injuries in football can be lessened by adequate conditioning programs, drills in fundamentals, adequate enforcement of safety rules and good, well-fitting, proper equipment.

REFERENCES

1. Albright JP, Moses JM, Feldish HG, Dolan KD, Burmeister LF: Non-fatal cervical spine injuries in interscholastic football. *JAMA* 236: 1243-45, 1976.
2. Alley RH Jr: Head and neck injuries in high school football. *JAMA* 188:418-422, 1964.
3. Babcock JL: Cervical spine injuries. *Arch Surg* 3:646-651, 1976.
4. Blythe C: *Fortieth Annual Survey of Football Fatalities*. Durham, N.C., The Commission on Competitive Safeguards and Medical Aspects of Sports of the National Collegiate Athletic Association, 1972.
5. Cahill BR, Griffith EH: Exposure to injury in major college football. *Am J Sports Med* 7:183-185, 1979.
6. Clinsman OD, Snook GA, Stanitis JM, Keedy VA: Lateral-flexion neck injuries in athletic competition. *JAMA* 192:613, 1965.
7. Clancy WG, Brand RL, Bergfield JA: Upper trunk brachial plexus injuries in contact sports. *Am J Sports Med* 5:209-216, 1977.
8. Clarke KS: Calculated risk of sports fatalities. *JAMA* 197:894-896, 1966.
9. Fielding JW, Fietti VG, Mordam-Bey TH: Athletic injuries to the atlanto-axial articulation. *Am J Sports Med* 6:226-231, 1978.
10. Funk FJ, Wells RE: Injuries of the cervical spine in football. *Clin Orthoped* 109:50-58, 1975.
11. Pearl AJ, Mayer PW: Neck motion in the high school football player. *Am J Sports Med* 7:231-233, 1979.
12. Reid SE, Reid SE Jr: Football, neck muscles, and head impact. *Surg Gynec Obstet* 147:513-17, 1978.
13. Reid SE, Tarkington JA, Essteim HM, O'Dea TJ: Brain tolerance to impact in football. *Surg Gynec Obstet* 133:929-35, 1971.
14. Stauffer ES, Rhoades ME: Surgical stabilization of the cervical spine after trauma. *Arch Surg* 3:652-657, 1976.
15. Schneider RC, Gosh HH, Norrell H, Jerva M, Combs LW, Smith RA: Vascular insufficiency and differential distortion of brain and cord caused by cervico-medullary football injuries. *Neurosurg* 33:363, 1970.
16. Schneider RC: Serious and fatal neurosurgical football injuries. *Clin Neurosurg* 12:226-236, 1964.
17. Schneider RC: *Head and Neck Injuries in Football*. Baltimore, Williams and Wilkins, 1973, p. 1-4.
18. Torg JS, Truex R, Quendenfeld TC, Burstein A, Speakman A, Nichols C: The national football head and neck registry. *JAMA* 241:1477-1479, 1979.

DESCRIPTION: Methyltestosterone 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D.; I. B. Sipahioglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250, Rx only.

When impotence is due to androgenic deficiency.

Android[®] / 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. / mg. / mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Preparticipation Evaluation for School Athletic Programs*

PAUL J. HIRSCH, M.D., STUART A. HIRSCH, M.D.,
LYNN REEDMAN, C.M.A., BERNARD A. RINEBERG, M.D.,
ANDREW B. WEISS, M.D., Newark

Active participation by physicians will improve safety in school athletic programs. The role of the physician in performance of the preparticipation physical examination is particularly considered. Also discussed is the physician's responsibility to help determine a safe level of participation for all students. Tables outlining qualification/disqualification and a classification for sports[†] participation are presented.

The interested participation by physicians is crucial to safety and proper perspective in school athletic programs. The school programs must look to the physician for:

- **Advice for young athletes and their parents**—Specific advice about a particular sport often is requested. Alternatives should be suggested if the desired sport is medically unacceptable. Physicians should be prepared to discuss the expected frequency of injury in various sports (e.g., high in football and wrestling; low in swimming).
- **Advice for school athletic programs**—The physician should help to establish policies and standards for healthful and safe participation for all students, including protective equipment, training and conditioning programs, and the encouragement of programs for all students.
- **Preparticipation examination**—This key physician task must be performed carefully and with knowledge of athletic programs.
- **Recommendations**—Specific recommendations for participation should be made, based upon the examination.
- **Team physician role**—This doctor provides on-field management of injuries, and determines whether an athlete may return to play after an injury.
- **Definitive treatment**—This may be provided by the team physician, the family doctor, or an appropriate specialist.

These roles will not necessarily, or even usually, be performed by the same doctor.

This report will emphasize the preparticipation evaluation,

which is one of the most important aspects of a physician's role in any school athletic program. The preparticipation evaluation, including a screening history, the examination itself, and the formulation of recommendations can be one of the most effective means of limiting injuries, as well as a means of helping the young athlete to find an appropriate level of participation in the program.

The circumstances of the evaluation will vary from one school system to another. It will depend upon the individual physicians who are available and interested, and on the facilities for examination. Under many circumstances the most appropriate physician to perform this examination is the young athlete's family physician. This doctor knows the youngster best, is likely to be familiar with his or her prior history, and should be able to schedule sufficient time to perform an adequate and complete evaluation. However, not all physicians are interested in performing preparticipation

*Read before the seminar on Preparticipation Examination of the School Athlete, presented by the Committee on Medical Aspects of School Sports, MSNJ, Lawrenceville, New Jersey, April 23, 1980. This is from the Division of Orthopedic Surgery, New Jersey Medical School, CMDNJ, where Dr. Paul Hirsch is clinical associate professor of surgery (orthopedics) and Dr. Weiss is professor of surgery (orthopedics); Drs. Stuart Hirsch and Rineberg are clinical assistant professors of surgery (orthopedics) at Rutgers Medical School, CMDNJ; Ms. Reedman is clinical research coordinator for Paul J. Hirsch, M.D., Stuart A. Hirsch, M.D., P.A. Correspondence may be addressed to the Drs. Hirsch, 720 Highway 202, Bridgewater, NJ 08807.

"History of prior injuries is important to help determine participation and to indicate those anatomical areas in which the youngster may be particularly susceptible to reinjury."

"A very thorough examination and special attention are important the first time a young athlete is examined for participation in a school program."

evaluations. Therefore, in some circumstances, one or several physicians will be designated to perform these evaluations for some or all participants in the program.

SCREENING HISTORY

As preliminary to the preparticipation evaluation a questionnaire should be completed by the athlete, with assistance by the parent. If the family physician is performing the examination, he or she also may be able to help with completion of the questionnaire and may provide information which has been overlooked by the family. A number of standard questionnaires are available, including one prepared by the American Medical Association. Our modification (Figure 1) emphasizes those factors which are particularly pertinent for participation in an athletic program. Questions are designed to help the family recall events or injuries which may have been forgotten.

History of prior injuries is important to help determine participation and to indicate those anatomical areas in which the youngster may be particularly susceptible to reinjury. Prior injury is an exceedingly important factor in the occurrence of future injury to the same area; therefore, the first preparticipation examination in the school system is most crucial. After that, the medical record will be best supplemented by a careful record of all injuries sustained by the athlete, in all activities.

THE EXAMINATION

If the examination is done at the school, adequate time and space should be provided. An adequate examination cannot be performed in a single, large, open room, with a horde of youngsters arriving at the same time. The lack of privacy is unreasonable and can prevent obtaining the complete history or performing a satisfactory examination. It should be possible to stagger the time of arrival of the youngsters and to provide for privacy.

The examination should be performed about one month prior to the beginning of the athletic program. This will permit time for additional consultation to clarify uncertain aspects of the examination or time to treat any deficiencies which might be correctable to permit participation. To retain validity, it should be no longer than six to eight weeks before the start of play.

A very thorough examination and special attention are important the first time a young athlete is examined for participation in a school program. This is the time that a previously unrecognized abnormality should be detected.

The medical examination should be performed according to the custom of the individual examining physician. Our standard outline is indicated in Figure 2.

All abnormal findings should be noted, but emphasis should be given to those pertinent to the athletic program. For example, the presence of skin infection would routinely

be noted on a physical examination, but a mild infection, particularly in a non-exposed area, might be of little importance in a football player. Alternatively, the presence of even a mild herpes virus infection in a wrestler would be of great significance, in view of the tendency for rapid spread to other participants. Healed scars might be overlooked in a general physical examination, but are more important here as clues to previous injury, which may have been forgotten or omitted from the history.

Some physicians feel that reexamination should be performed before each program, generally with a change in the seasons. We believe that this is a waste of time. Annual examinations are also unnecessary. If the first examination is complete, and if meticulous records of injuries are kept, a complete reexamination should be necessary no more often than every two to three years. There should of course be reexamination following injury and rehabilitation before resuming athletic activity. Decreasing the frequency of complete physical examinations should increase the time available for each examination.

Success of these programs depends not upon frequent examinations, but upon a thorough first examination, good records of injuries, and the interest and involvement of physicians, coaches, and trainers in the local program.

RECOMMENDATIONS

Based upon the screening history and the examination the physician has an obligation to make specific recommendations. He should indicate the ability to participate in the sport in question, and should also be ready to suggest alternatives if participation in a desired sport is not possible on either a temporary or permanent basis.

The physician's recommendations should be precise and in general will conform to one of five categories:

1. No limitations
2. Recommendation of another more appropriate sport
3. Deferred, additional consultation will be obtained as soon as possible. (In general, this is the only reason for deferral.)
4. Disqualification from all participation. (This rarely will be used, except for acute injuries.)
5. Advise treatment of remediable conditions.

CLASSIFICATION OF ACTIVITIES

A "Classification Program for School Athletic Activities" (Figure 3) is used to guide participation. Our classification borrows from other similar classifications. We use this listing to encourage uniformity of expression regarding medically permissible levels of participation. Placement of a sport within a specific category may vary from one community to the next, based upon the perception of that sport by the athletic director, or the way in which the sport is played in that locality. Specific placement of that sport is much less important than the general concept which should be avail-

Figure 1
Questionnaire

For Participation in Sport and Athletic Programs
To be completed by the athlete, assisted by parents.

Name: _____ Date of Birth: _____ M/F _____

Parents Name: _____

Address: _____

_____ Telephone no.: _____

	YES	NO
1. Were you ever medically advised not to play any sport?	_____	_____
2. Are you under a physician's care now?	_____	_____
3. Were you ever unconscious after an injury	_____	_____
4. Have you ever had a fracture or dislocation?	_____	_____
5. Have you ever had any surgery?	_____	_____
6. Have you ever had to stay in a hospital overnight?	_____	_____
7. Do you take any medications every day?	_____	_____
8. Do you have any allergies?	_____	_____
9. Do you have any worries about your health, or think that there may be any reason why you could not participate in sports?	_____	_____
10. Are there any questions which you would like to discuss with a doctor?	_____	_____

If you answered yes to any questions above, please explain: _____

(Continue on reverse side if necessary.)

Year of last tetanus toxoid booster _____.

Signature of Parent

able to coaches, trainers and physicians. It is relatively easy to decide what an athlete cannot do; it is frequently difficult to decide what is permissible. The use of this classification as a guideline should make it easier to find categories, or specific sports within a category, in which an athlete can participate when there are some limits. It also will help some physicians who may not be completely familiar with athletic programs.

We believe it is particularly important that, under some circumstances, the athlete be permitted to set his or her own guidelines. The physician and the coach can decide when this is appropriate, based upon the physical examination, and upon the emotional maturity of the athlete. Placing an athlete on a self-limit basis, indicated by an asterisk (*) in our guidelines, will permit participation in a more strenuous category than would be possible with fixed limitations.

DISQUALIFICATIONS

In considering disqualification for a particular activity, it is important to determine in which sport the youngster may participate. Although there may be valid medical reasons for not participating in some areas, the physician, the coach, and the physical education instructor should all look for ways in

which the young person will be able to enjoy activity within his or her capability.

Physicians often will find it easier to completely disqualify a youngster from all participation, especially for an acute problem, but it would be best if some level of activity were permitted. Similarly, many physical education and athletic departments have an "all or nothing" rule, which requires that the youngster be able to participate fully and in all activities or not at all. There must be recognition of the ability to do some things. The self-limit category in our guidelines will allow this. It would be as important for the youngster taking standard physical education classes, as for the one on a competitive team.

In the past, physical education requirements that all students participate in all activities and drills, has led to disenchantment with athletic activity and accounts, in part, for requests for "gym notes" from the physician. Physical education programs should seek to find a meaningful level of participation for all youngsters, and one which they will enjoy rather than an inflexible program which will discourage them from athletic activity.

To guide physicians, a list of disqualifications is useful. Our guidelines (Figure 4) follow similar programs, with those

Figure 2
Pre-Participation Physical Examination

This should be a standard medical examination, according to the custom of the examining physician. Any remarkable or abnormal findings should be noted, emphasizing those pertinent to participation in the athletic program. Some items of importance are noted. All categories should be examined.

NAME _____ AGE _____ M/F _____

HT. _____ WT. _____ B.P. _____

SKIN: Presence of infection. Scars of previous surgery or trauma. Jaundice.

HEENT: Note eyeglasses or contact lenses. Visual acuity by eye chart.
Conjunctiva for jaundice.
Ear drums — acute or chronic infection.
Nose — significant deformity may affect endurance.

NECK: Should have full and painless range of motion.

CHEST: Contour. Pectus excavatum/carinatum.

LUNGS: Auscultation.

HEART: Murmurs. Rhythm. Rate.

ABD: Hepatomegaly. Splenomegaly. Hernia

BACK: Range of motion. Instability.
Scoliosis which does not require treatment, does not require activity limitation.

EXTREMITIES: Abnormal mobility or immobility.
Deformity. Instability. Muscle weakness/atrophy.

FEMALE — PELVIC EXAM: Only when specifically indicated by medical history.

MALE — GENITALIA: Testes descended.

MATURATION: (According to local procedures.)

LAB: Urinalysis: Glu. _____ Act. _____ Prot. _____ (Dip-stick)
Hct. _____ Hgb. _____

modifications which we believe desirable. Activities which commonly are strenuous when performed competitively, may be performed in a non-strenuous manner at other times. Every effort should be made to permit the candidate to participate.

Recent injuries of any significance nearly always will disqualify a student from competitive sports on a temporary basis. "Playing hurt" may have its role in professional athletics, but hardly ever in school sports. The youngsters must be given time for healing and for adequate rehabilitation before resuming participation. Competitive level activities, well tolerated by the conditioned athlete, place at great risk the deconditioned athlete who recently has been injured. Old injuries rarely prohibit participation, provided there has been complete rehabilitation and that appropriate precautions are directed toward the injured area.

Chronic diseases and chronic situations rarely prohibit participation in all activities. Virtually every child can participate in at least minimally strenuous activities, except for

those who have sustained recent severe injuries and require healing and rehabilitation before resuming participation.

SUMMARY

The preparticipation evaluation can increase safety in school athletic programs, by recognizing risk factors. The physician should guide those who cannot perform in their desired sport to another area. Only rarely will a young athlete be prohibited from all participation. Guidelines have been presented to assist with disqualifications, and to encourage placement of all students in some athletic activity. The physician's role in providing this information is crucial to safe and successful school programs which provide opportunity for all students.

Some of the material in this paper has been adopted as official policy by the Committee on the Medical Aspects of School Sports, and approved by the Board of Trustees of the Medical Society of New Jersey

Figure 3
Classification Program for School Athletic Activities

The purpose of this classification is to encourage uniformity of expression, regarding medically permissible levels of participation in school sport programs. Placement of a sport within a specific category may vary in different communities. Some sports are especially suitable for play at less strenuous levels than might be seen in general competition; additional levels are indicated by parentheses. Adapting a sport to another category is encouraged. Not all activities within a category will be appropriate for a given individual, an asterisk (*) after a category could note a recommendation that the athlete "self-limit."

	I. Contact Collision/Combat	II. Limited Contact	III. Non-Contact
a. Strenuous	Lacrosse Football Hockey Wrestling Rugby	a. Basketball Soccer Volleyball Touch Football Field Hockey	a. Endurance Cross Country Track Swimming Gymnastics Crew Cycling Tennis Skiing Fencing Non-Endurance Field Events Weight Lifting (Swimming)
b. Moderately Strenuous		b. Baseball (Basketball) (Volleyball)	b. Golf Table Tennis Badminton (Swimming)
c. Minimally Strenuous			c. Archery Riflery Bowling (Swimming) (Golf)

Figure 4
Suggested Guidelines

There are only a few absolute disqualifications. The physician should not only qualify/non-qualify; there should be an effort to find an activity which is appropriate for the young athlete. Chronic conditions rarely prohibit minimally strenuous activities. Judgment must be individualized. Activities which are commonly strenuous, may be performed in a non-strenuous manner when not done competitively: swimming, for example, may be strenuous, moderately strenuous, or minimally strenuous; it may or may not require endurance, depending upon how performed.

CONDITION	COMMENTS
Acute Infections	Temporary limitation until cleared.
Bleeding disorders, hemophilia	Omit contact/combat classification (Category I). Can practice in others.
Tuberculosis	No contraindication after controlled and on chemotherapy for two months.
Asthma	When controlled, no contraindication.
Seizure disorder, epilepsy	When controlled, no contraindication.
Diabetes	When controlled, no contraindication.
Enlarged liver/spleen	Disqualify for contact and limited contact sports (Categories I, IIa, and IIb) until organs return to normal size.
Concussion/severe neck injury	If two or more, no Category I sports.
Recent injury	Time for healing and rehabilitation of the injured part.
Cardiovascular	This group especially requires individual consideration, and evaluation by the athlete's cardiologist.
Mitral or aortic stenosis, aortic insufficiency, coarctation of the aorta, recent carditis.	Generally disqualifying for all sports except Category IIIc, possibly IIlb.
Previous cardiac surgery	May or may not be disqualifying.
"Functional" murmurs, arrhythmias which disappear with exercise.	Generally not disqualifying.
Hypertension	If diastolic pressure over 85, to be determined individually. If controlled, generally not disqualifying.
Absence of loss of function of one member of paired organs: kidneys, eyes, testes (absent or undescended). (Ovaries are best-protected organs.)	This is an area of controversy. Should a player and parents insist upon participation, the dangers must be carefully explained. Generally, absence of one kidney or one eye should disqualify for Category I, and possibly Category II sports. If an athlete with one testis is to participate in Category I sports, specific attention must be paid to protection.
Scoliosis	Not disqualifying if does not require bracing or surgery.
Osgood-Schlatter's syndrome and other forms of apophysitis.	Symptomatic treatment; self limitation according to discomfort.
Spina bifida/occulta	No clinical significance
Spondylolysis-spondylolisthesis	If slip less than 25% and symptoms minimal, no specific restrictions; if 25% or more, no category I activities. Lateral standing x-ray at regular intervals, through growth.
History of Legg Perthe's Disease	If healed without residual, no restrictions necessary.
History of Slipped Capital Femoral Epiphysis	Consider restriction of Category I activities, in view of predisposition to contralateral slip. Presence of internal fixation device may also be limiting.
Artificial limb	Individual consideration. In general allow participation to limits of ability.

Chemical Fire at Toxic Waste Disposal Plant: Epidemiologic Study of Exposure to Smoke and Fumes*

WILLIAM HALPERIN, M.D., PHILIP J. LANDRIGAN, M.D.,
RONALD ALTMAN, M.D., ALFRED W. IACI, M.S.,
DALE L. MORSE, M.D., LARRY L. NEEDHAM, Ph.D.

On December 8, 1977, a waste-chemical disposal plant in New Jersey exploded and burned. Among the chemicals combusted were polychlorinated biphenyls (PCB), which led to concern that PCB combustion might have produced tetrachlorodibenzofuran (TCDF) or tetrachlorodibenzodioxin (TCDD). To determine whether these products had formed and to evaluate the health effects of exposure to the fire, we conducted environmental and epidemiologic investigations.

Industrial fires are commonplace—50,000 occurred in 1976 in industry, utilities, and defense establishments.¹ Toxic fumes from these fires are a health hazard both for firefighters who battle them as well as for nearby residents. In this paper we present results of an epidemiologic investigation of an unusual fire in a toxic waste disposal plant. This experience illustrates the need for toxicologic evaluation of complex industrial fires and emphasizes the need for providing firefighters with proper equipment and training in order to minimize adverse health effects of exposure to such fumes.

On December 8, 1977, a fire occurred at a waste-chemical disposal plant in New Jersey. Conditions at this fire exemplify many of the problems seen in modern industrial fires. The list of chemicals involved was long, and many of the commercial chemical products were not fully characterized; firefighters and health authorities became concerned about the toxicities of the chemicals and their combustion products only after the fire was quenched; access to the fire site was inadequately controlled; many firefighters and rescue workers were volunteers, inadequately trained and poorly equipped to fight industrial fires; finally, among the compounds in the fire were polychlorinated biphenyls (PCB), and the possibility existed, based on laboratory research,^{2,3} that highly toxic tetrachlorodibenzofuran (TCDF) or tetrachlorodibenzodioxin (TCDD) might have formed in the combustion of PCB and might have contaminated persons at the fire, equipment or surrounding communities.

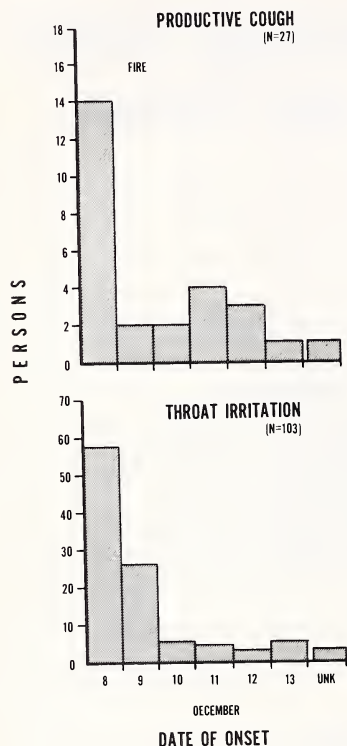
BACKGROUND

The toxic waste-disposal plant, located in rural southern New Jersey, consisted of tanks for the storage of industrial waste, high-temperature incinerators, and ancillary buildings. The stored waste contained a variety of substances such as PCB, benzene, methylene chloride, aniline and sludge. A series of explosions in storage tanks and fires began at about 2:30 p.m. on Thursday, December 8, 1977. Five workers died in the blaze, and one died subsequently of burns. During the fire, numerous company employees, first-aid units, police, volunteer fire companies, journalists and spectators, including a U.S. congressman, were present and had varied exposure to fumes and smoke.

Although many attendees developed symptoms during and

*This study was carried out by the Center for Disease Control, U.S. DHEW and the New Jersey State Department of Health, Division of Laboratories and Epidemiology. Dr. Halperin was affiliated with the Field Service Division, Bureau of Epidemiology and the Division of Surveillance, Hazard Evaluations and Field Studies, National Institute for Occupational Safety and Health, Center for Disease Control, Public Health Service, U.S. DHEW, Atlanta, Georgia, and with the Division of Laboratories and Epidemiology, New Jersey State Department of Health, Trenton. Dr. Altman and Mr. Iaci were members of the staff at the latter. Dr. Landrigan, Dr. Morse and Dr. Needham were affiliated with the Center for Disease Control. Correspondence may be addressed to Dr. Halperin, Industry-wide Studies Branch, National Institute for Occupational Safety and Health, 4676 Columbia Parkway, Cincinnati, Ohio 45226.

DATE OF ONSET OF PRODUCTIVE COUGH OR THROAT IRRITATION



after the fire, prompting a request on December 9 for public health evaluation of the significance of the fire for attendees and residents living nearby, it was not until later that day that a toxicologist reviewed the list of agents that had burned and suggested that combustion of the large volume of PCB solutions (greater than 15,000 gallons) may have produced TCDD or TCDF, highly toxic chemicals. TCDD is a contaminant in the manufacture of the herbicide 2,4,5-trichlorophenoxyacetic acid, a constituent of Agent Orange, and was the agent responsible for illness in Seveso, Italy,⁴ when machinery at a plant manufacturing trichlorophenol as a feedstock for hexachlorophene malfunctioned.

At that stage, officials of local, state, federal governments and agencies were faced with the following problems: the uncertainty as to whether TCDD or TCDF had been produced, the certainty that large numbers of attendees had been exposed to smoke and fumes and were symptomatic, the certainty that fire and rescue equipment had been contaminated by fire effluent, the possibility that a toxic plume may have contaminated a few residents nearby and, less likely, a greater number further away. Decisions were made to evacuate nearby residents, limit access to the fire site except to essential, adequately protected personnel, identify individuals exposed during the fire and determine their health status, and conduct an environmental survey to determine the extent of TCDD or TCDF contamination, if any.

METHODS

Questionnaire Survey: We obtained names of persons at the fire by contacting fire companies, police, rescue squads, civil defense groups, and other groups who had participated, as well as by making a general appeal in the news media for exposed individuals. In the period December 11 to 14, a questionnaire (furnished on request by WH) was administered to exposed persons, either in small groups or individually by telephone.

Four hundred and forty (95.9%) of the 459 persons known to have been present at the fire were surveyed. On December 19, eleven days after the fire, a followup questionnaire was administered to 96 (91.4%) of the 105 persons who reported respiratory symptoms on the first questionnaire. On February 16, 54 days after the fire, 36 of the 37 persons (97.3%) who reported any residual symptoms on the second questionnaire were questioned a third time as to the persistence of their symptoms.

Environmental Survey: In collaboration with the New Jersey Department of Environmental Protection, the U.S. Environmental Protection Agency, and the U.S. Occupational Safety and Health Administration (OSHA), on December 10 we collected surface soil samples at points throughout the fire zone and at more distant control sites. Also, we obtained wipe samples with alcohol-impregnated sponges from the surfaces of firefighting equipment used at the fire.

Laboratory Methods: The soil and wipe samples were examined starting on December 10 by the Toxicology Branch, Clinical Chemistry Division, Bureau of Laboratories, Center for Disease Control for TCDD and for TCDF with use of gas chromatography and mass spectroscopy and with comparison against authenticated standards. Detection limits were 100 parts per billion (ppb) for TCDD and 10 ppb for TCDF.

RESULTS

Medical Survey Data: Two patterns of symptoms were found in the 440 persons whom we interviewed. The first symptom complex consisted of respiratory complaints and included throat irritation in 103 (23%), nonproductive cough in 77 (17%), chest pain in 54 (12%), shortness of breath in 42 (10%), productive cough in 27 (6%), and hemoptysis in 3 (0.7%). The second symptom complex was neurologic and usually occurred in persons who also manifested respiratory symptoms. The most frequent symptoms included headache in 161 (37%) and dizziness in 75 (17%). Other symptoms reported were eye irritation by 70 (16%) persons, nausea or vomiting by 64 (14%), and skin irritation by 59 (13%).

Onset of symptoms occurred primarily on the day of the fire and the day following, with only a small number of persons having onset in subsequent days (Figure 1). For most persons onset of symptoms occurred within five to ten hours after arrival at the fire.

An analysis of risk factors showed no statistically significant differences in symptom incidence between those persons closest to the fire site and those who had remained on the periphery. However, for those persons closest to the fire site, the incidence rates for six of twelve symptoms were associated positively with duration of exposure (Table 1). For those who remained on the periphery, only dizziness was associated with length of exposure.

Analysis of symptom incidence rates by profession showed that firefighters had significantly more frequent throat irrita-

Table 1
Symptom Incidence Rates for Persons Exposed to Plant Fire
by Duration of Exposure, New Jersey, December 8-9, 1977

Exposure Duration (hour)	Number of Persons	Percentage with Symptom					
		Dizziness	Chest Pain	Headache	Shortness of Breath	Dry Cough	Nausea or Vomiting
		(N=61)	(N=43)	(N=215)	(N=36)	(N=61)	(N=47)
< 2	117	10.2	4.3	28.2	5.1	9.4	7.7
2-6	143	23.8*	18.2*	46.8*	13.3*	25.2*	17.5*
> 6	62	24.2	19.3	40.3	17.7	22.6	21.0
Total	322	18.9	13.3	38.8	11.2	18.9	14.6

* Z-statistic for exposure of less than 2 hours v. exposure of 2-6 hours v. exposure of >6 hours ≥ 1.96 , $p < 0.05$.

A statistically significant association was not seen for skin, eye, or throat irritation, hemoptysis, productive cough, or sleepiness.

tion ($p < .01$), dry cough ($p < .05$), and chest pain ($p < .05$) than did persons in other occupational categories. Workers employed at the chemical disposal plant had no significant excesses in the incidence of any symptoms and, indeed, had significantly lower rates than persons in all other categories for headache, dizziness, eye irritation, and dry cough.

Age-specific attack rates were calculated to determine whether age had played a role in the occurrence of symptoms. No consistent gradients with age were observed, except that headache was significantly more frequent in persons under age 30 (40.2 percent) than in those 30 years old and above (20 percent) ($\chi^2 22.44$, $p < 0.001$).

There was no relationship noted between occurrence of symptoms and history of heart, lung, or other chronic disease or with smoking history.

Only 28 (6.4 percent) of the 440 persons exposed to the fire had used protective respirators. For those two occupational categories with highest frequency of respirator use (firemen and policemen), we calculated attack rates for all symptoms for those persons who had used and those who had not used respirators. Generally, attack rates were higher for those who had used protection, a finding which may reflect their more intense exposure to the fire. Sleepiness ($p < 0.004$) was significantly more frequent in respirator users than in non-users.

Analysis of the persistence of symptoms showed that symptoms generally abated within one week after onset. A few persons, however, still exhibited symptoms after 60 days (Figure 2).

Laboratory Results: Analysis of surface soil and wipe samples at CDC by gas chromatography and mass spectroscopy showed no evidence of either TCDD or TCDF in any environmental sample.

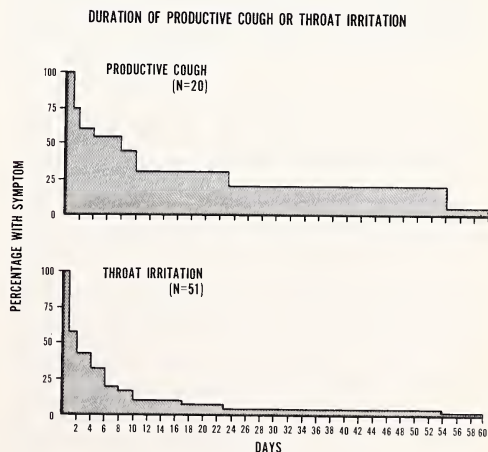
Discussion: Firefighters and other persons at the disaster scene in southern New Jersey were exposed to smoke and fumes. Such exposure is evident not only by anecdote, but also from the frequent occurrence of smoke and fire-related symptoms that occurred in many persons present at the scene. Fortunately, these symptoms were not severe and generally not of long duration. This relative mildness resulted, however, less from any precautions taken at the fire than from the fortuitous absence of high concentrations of highly toxic fumes. Because of the complex mixture of chemicals present, it is impossible to say which specific exposures or exposure combinations resulted in the observed symptoms.

This disaster presented a particular dilemma to health and environmental authorities in that the possibility was raised soon after the fire that the extremely dangerous chemical toxicants TCDD or TCDF might have been produced in the

conflagration. Attention thus had to be focused on several procedures: (1) rapid environmental sampling for TCDD and TCDF, (2) limitation of potential exposures after the fire while awaiting laboratory evaluations for the presence of TCDD and TCDF, (3) contingency planning for evacuation had these chemicals been present, and (4) monitoring of persons present at the fire for the effects of exposure to these toxins. Fortunately, neither of these highly toxic chemicals was found in this instance, and early restrictions were relaxed. However, the potential for the generation of these toxic chemicals under similar conditions has subsequently been reasserted.⁵

Disasters such as this fire are both a reminder of the continuing hazards of the workplace and a warning to civil officials to prepare for the large-scale chemical emergencies that may occur in modern industrial establishments.⁴ We believe that officials familiar with human toxicology must be involved in the management of similar catastrophes in order to ensure that potential health hazards are considered and appropriately assessed.

Firefighting is perceived by firefighters as a hazardous occupation. "When a guy gets hurt at a fire, it's easier to remember the injury than the man's name. There are many names, but the injuries are all about the same—a guy got burned, he fell through the roof or a floor, he got cut by falling glass, the ceiling or a wall fell on him, or he was overcome by heat or smoke. These injuries can't be prevented, not as long as the best way to put out a fire is to get close to it."⁶ In fact, the risk of accidental death for



firefighters is excessive, approximately 35 percent higher than for the general population.⁷ Firefighters are also at higher increased risk of acute and chronic work-related injuries. They lose pulmonary function at twice the expected rate, and this accelerated rate of loss is related significantly to frequency of fire exposure.⁸ They suffer higher frequency of chronic obstructive lung disease.^{9,10}

A peculiarly modern threat to the health of firefighters is the hazard of exposure to toxic gases and fumes formed during combustion of chemical and plastic products.¹¹⁻¹⁴ Examples of toxic fumes involved in such exposures include hydrochloric acid fumes formed in the combustion of polyvinyl chloride¹⁵ and combustion products of polytetrafluoroethylene, Teflon,^a which may induce "polymer fume fever,"¹⁶ and hydrogen cyanide, which may be formed in the burning of the acrylonitrile plastics,¹² used widely in the formation of pipe and floor tiles.

Firefighters should not be exposed unnecessarily to dangerous substances in firefighting. Exposure could be minimized through (1) limiting the number of trained firefighters to those necessary to handle the fire and, even more importantly, of untrained ancillary personnel allowed at the fire scene, (2) using appropriate safety equipment for respiratory and cutaneous protection, and (3) having readily available to local authorities inventories of the chemicals and toxins present on industrial sites and of their potential combustion products. Furthermore, regular and volunteer fire departments and rescue squads should be alerted to the particular consequences of fires in industries in their locales so that these personnel can be properly trained and equipped.

SUMMARY

On December 8, 1977, a waste-chemical disposal plant in New Jersey exploded and burned. Among the chemicals combusted were polychlorinated biphenyls (PCB), and there was concern that PCB combustion might have produced tetrachlorodibenzofuran (TCDF) or tetrachlorodibenzodioxin (TCDD). To determine whether these products had formed and to evaluate the health effects of exposure to the fire, we conducted environmental and epidemiologic investigations.

No TCDF or TCDD was detected in soil samples or in wipe samples of fire fighting equipment; detection limits were 10 parts per billion (ppb) and 100 ppb, respectively, for TCDF and TCDD. Evaluation of 440 (96%) exposed persons showed that symptoms had developed in 270 (61%), usually within five to ten hours after arrival at the scene. Respiratory

symptoms were most common and included throat irritation in 103 (23%), cough in 77 (17%), shortness of breath in 42 (10%), and pleuritic pain in 54 (12%). The highest incidence of respiratory symptoms was for firefighters. Incidence rates for six of twelve symptoms were associated with duration of exposure. Firefighters and other emergency workers should be trained and equipped to deal safely with toxins encountered at industrial fires.

REFERENCES

1. Derry L: A study of United States fire experience. *Fire Journal* 71:50-53, 1977.
2. Morita M, Nakagawa J, Rappe C: Polychlorinated dibenzofuran formed from PCB mixture by heat and oxygen. *Bull Environm Contam Toxicol* 19:665-670, 1978.
3. Buser HR, Bosshardt HP, Rappe C: Formation of polychlorinated dibenzofurans from the pyrolysis of PCBs. *Chemosphere* 1: 109-119, 1978.
4. Fuller JG: *The Poison that Fell from the Sky*. New York, Random House, 1977.
5. O'Rell MK: Fate of PCB's in Rollins Environmental Services plant fire. EPA Contract No. 68-02-2165. Washington: U.S. Environmental Protection Agency, 1978.
6. Smith D: *Report from Engine Co. 82*. New York, Pocket Books, 1973.
7. Musk AW, Monson RR, Peters JM, Peters RK: Mortality among Boston firefighters, 1915-1975. *Br J Ind Med* 35: 104-108, 1978.
8. Peters JM, Theriault GP, Fine JF, Wegman D: Chronic effect of firefighting on pulmonary function. *N Engl J Med* 291:1320-1322, 1974.
9. Loke J, Matthay RA, Farmer WC, Rutman CE: Acute and chronic effects of firefighting on pulmonary function. *Am Rev Respir Dis* 4:247, 1978.
10. Musk AW, Peters JM, Rubin C: Acute changes in one-second forced expiratory volume in firefighters and their possible relationship to chronic changes. *Am Rev Respir Dis* 41:25, 1978.
11. Axford AT, McKerrow CB, Parry Jones A, LeQueune PM: Accidental exposure to isocyanate fumes in a group of firemen. *Br J Ind Med* 33:65-71, 1976.
12. Terrill JB, Montgomery RR, Reinhardt CF: Toxic gases from fires. *Science* 200:1343-1347, 1978.
13. Gold A, Burgess WA, Clougherty EV: Exposure of firefighters to toxic air contaminants. *Am Ind Hyg Assoc J* 39:534-539, 1978.
14. Smith TJ, Musk AW, Gold A, Roto P: Acute respiratory effects of a fire involving silicone rubber. *Int Arch Occup Environ Health* 41:139-145, 1978.
15. Dyer RF, Escsh VH: Polyvinyl chloride toxicity in fires: Hydrogen chloride toxicity in firefighters. *JAMA* 234:393-397, 1972.
16. Eckardt R: The health hazards of plastics. *J Occup Med* 15:808-819, 1973.

^aInclusion of trade name is for identification only and does not imply endorsement by the U.S. Public Health Service.

STATE OF THE ART

Cimetidine: Use, Abuse and Overuse

GEOBEL A. MARIN, M.D., Trenton*

Cimetidine is a potent inhibitor of gastric acid secretion. It is an extremely useful medication in the management of peptic ulcer disease of the duodenum and stomach and it has been found to be of value in the management of peptic esophagitis. Its actions are complex and side effects may occur; hence, its use should be restricted to those conditions in which the drug has been found to be of value. There is now evidence that cimetidine may affect the metabolism of many other drugs and physicians must be alert to the possibility of important drug interactions.

Few drugs have received wider acceptance than cimetidine in recent years. The justifiable expectations that preceded its clinical use in patients with ulcer disease were tempered when it became clear that, like so many other medications tried before, the new histamine H_2 -receptor antagonist was not the final answer to the ulcer problem. Furthermore, it would appear that the drug is being prescribed with little discrimination and, quite possibly, with little rationale in many instances.

INITIAL CONSIDERATIONS

Histamine had been recognized as playing a crucial though not totally clear role in gastric acid secretion. The classic antihistamines developed in the 1940s were known to block certain histamine actions—for instance smooth muscle contractions in various organs such as guinea pig ileum, bronchus and uterus; they were, however, totally ineffective in blocking the ability of histamine to stimulate gastric acid secretion. This simple fact followed by other pharmacological observations and the testing of dozens of different substances able to inhibit histamine-stimulated gastric secretion, led Blac, Brimblecombe and others at the Smith Kline and French laboratories, together with Ash and Schild, to postulate the existence of two different cell receptors for the histamine molecule: H_1 -receptors responsible for the action of histamine in smooth muscle (bronchoconstriction, for instance) and H_2 -receptors responsible for histamine-induced

gastric acid secretion. The doors then opened for the discovery of specific substances able to block the histamine H_2 -receptors that should, theoretically at least, suppress acid secretion and thus lead to ulcer healing.¹

This background information led to the discovery and manufacture of cimetidine. It was preceded by the synthesis of other substances which were tried and rejected and is being followed by the trial of other chemical compounds that may turn out to be more effective than cimetidine in suppressing acid secretion.

PHARMACOLOGY

Cimetidine is a specific competitive antagonist of histamine H_2 -receptors with no known significant interaction on catecholamine beta-receptors or histamine H_1 -receptors. It is available for oral (tablets and liquid) and parenteral (intravenous or intramuscular) use. Tablets and liquid doses are bioequivalent, i.e., equivalent doses lead to similar blood levels. As expected, the intravenous and intramuscular routes give quicker and higher blood levels than oral doses but all three routes provide blood levels of the drug which are able to suppress basal acid secretion by more than 80 percent and food stimulated secretion by more than 50 percent. This degree of suppression is probably adequate to promote ulcer

*Dr. Marin is a member of the staff of the gastrointestinal section of the Mercer Medical Center, Trenton. He may be addressed at 416 Bellevue Avenue, Trenton, NJ 08618.

"It has been administered to over twelve million patients since 1974 but serious side effects have been rare.³"

"... cimetidine should not be used in the treatment of patients with acute pancreatitis."

healing in most patients. The conclusion is, then, that the recommended doses are effective independently of the route of administration.

The drug is absorbed almost completely orally and 70 percent is excreted intact in the urine when the drug is given intravenously or intramuscularly. However, after an oral dose, only 48 percent is recovered in the urine, probably the result of a "first pass" effect, i.e., liver metabolism. The large urinary excretion accounts for the need to modify the dose in the presence of renal disease; should renal insufficiency be present, the dose should be reduced to 50 percent of the recommended 300 mg dose every six hours; with severe renal insufficiency the dose should be reduced to 300 mg every twelve hours.²

TOXIC EFFECTS

Cimetidine has proved to be remarkably safe. It has been administered to over twelve million patients since 1974 but serious side effects have been rare.³ Transaminase elevation, clinical cholestatic hepatitis possibly due to hypersensitivity, interstitial nephritis, transient cardiac atrioventricular conduction defects and decreased sperm counts have been described. These side effects appear to be very rare or mild enough so as not to cause serious concerns.

Two more important side effects have been encountered.⁴ First, mental confusion has been found, mostly in the elderly and in the presence of large doses; lethargy, disorientation, hallucinations and even convulsions also have been noted. The mechanism of these effects is unknown but it may be related to the blockade of histamine as a neurotransmitter in the central nervous system. Second, hematologic suppression has been reported to occur when the drug was administered to some patients with a previously normal bone marrow function; most of these cases have been reversible but a case of fatal agranulocytosis was reported.⁵ This case was unique in that the dose used was 300 mg four times a day for four weeks and no other medication was being used. The bone marrow showed complete suppression involving all three cell lines. This was considered an idiosyncratic reaction, similar to that seen with chloramphenicol. Admittedly, it must be very rare.

CLINICAL INDICATIONS

Clinical trials demonstrated the efficacy of cimetidine in the treatment of peptic ulcer disease; it was shown to be superior to placebo in the healing of duodenal ulcer, gastric ulcer and peptic esophagitis. This drug has been used advantageously in the management of severe gastroesophageal reflux and scleroderma, a condition known to be particularly prone to induce esophageal strictures.⁶ The recurrence of duodenal ulcer also has been found to be decreased when patients in whom the ulcer has healed on

endoscopic examination, are maintained on cimetidine 400 mg in the morning and 400 mg at bedtime.⁷ However, once the medication is discontinued, the recurrence rate equals that of control groups. Although it also has been found to be effective in preventing acute upper gastrointestinal bleeding in seriously ill patients, the number of patients that bleed is higher than when antacids are used frequently.⁸ Thus, the cumulative data available at present do not support the viewpoint that cimetidine is the drug of choice to prevent upper gastrointestinal bleeding in the acutely ill patient.

The drug appears to be of no value in acute pancreatitis, including the management of alcoholic pancreatitis and it has been incriminated in the production of experimental pancreatitis in rats.⁹ At present cimetidine should not be used in the treatment of patients with acute pancreatitis.

There is little doubt that the drug is being overused and prescribed for conditions in which its value neither has been proved nor authorized by the Federal Drug Administration. In a recent study of 200 hospital patients receiving cimetidine only 7.5 percent received the drug for FDA-approved indications.¹⁰ I have seen cimetidine prescribed for abdominal pain of unknown origin, flatulence, concomitantly with aspirin and prednisone in an attempt to prevent possible gastrointestinal bleeding, for constipation and for rectal bleeding. It appears that cimetidine has been considered a panacea in the hands of non-discriminating physicians. This trend should be discouraged for it may lead to untoward reactions to the drug in patients in whom there was no need to receive the medication.

Special care appears to be warranted when cimetidine is co-administered with other medications for drug interactions may have important therapeutic implications. Cimetidine inhibits hepatic drug-metabolizing enzymes leading to the impaired elimination of drugs such as diazepam, warfarin and chlorthalidopoxide. Furthermore, liver blood flow has been found to be decreased by as much as 33 percent after seven days of conventional cimetidine administration. This has resulted in a reduction in the clearance of oral propranolol.¹¹ Thus, it is clear that the systemic effects of

"Special care appears to be warranted when cimetidine is co-administered with other medications for drug interactions may have important therapeutic implications."

cimetidine may lead to important changes in the metabolism of other medications and that caution is needed to avoid the possibility of cumulative effects.

SUMMARY

Cimetidine has revolutionized the management of peptic ulcer disease. It is effective in treating patients with duodenal and gastric ulcers and it prevents duodenal ulcer recurrence when given for prolonged periods of time. It is beneficial in the management of gastroesophageal reflux ("heartburn") and it diminishes the possibility of acute upper gastrointestinal bleeding in the severely ill patient, though to a lesser degree than antacids. It has potential side effects involving the liver, the hematopoietic system, the central nervous system and many endocrine organs. It should not be used indiscriminatively or for minor gastrointestinal disturbances. Patients who take the medication should be monitored to detect possible side effects and important drug interactions.

REFERENCES

1. Brimblecombe RW, Duncan WAM, Durant GJ, *et al*: Characterization and development of cimetidine as a histamine H_2 -receptor

antagonist. *Gastroenterol* 74: 339-347, 1978.

2. Ma KW, Brown DC, Masler DS, *et al*: Effects of renal failure on blood levels of cimetidine. *Gastroenterol* 74: 473-477, 1978.

3. Ritchter JE, Gerhardt DC, Pasquale DN, *et al*: Cimetidine and hematologic suppression. *Dig Dis & Sc* 25: 960-963, 1980.

4. McGuigan JE: A consideration of the adverse effects of cimetidine. *Gastroenterol* 80: 181-192, 1980.

5. Chang H, Morrison S: Bone marrow suppression associated with cimetidine. *Ann Intern Med* 91: 580-583, 1979.

6. Petrokubi RJ, Jeffries GH: Cimetidine versus antacid in scleroderma with reflux esophagitis. *Gastroenterol* 77: 691-695, 1979.

7. Burland WL, Hawkins BW, Beresford J: Cimetidine treatment of the prevention of recurrence of duodenal ulcer: An international collaborative study. *Postgrad Med* 56: 173-176, 1980.

8. Stothert JC, Simonowitz DA, Dellinger EP, *et al*: Randomized prospective evaluation of cimetidine and antacid control of gastric pH in the critically ill. *Ann Surg* 192: 169-174, 1980.

9. Meshkinpour H, Molinari MD, Gardner L, *et al*: Cimetidine in the treatment of acute alcoholic pancreatitis. A randomized, double-blind study. *Gastroenterol* 77: 687-690, 1979.

10. Schade RR, Donaldson RM: Indications for the use of cimetidine in hospitalized patients. *Gastroenterol* (Abstract) 78: 1253, 1980.

11. Feely J, Wilkinson GR, Wood AJJ: Reduction of liver blood flow and propranolol metabolism by cimetidine. *N Engl J Med* 304: 692-695, 1981.

CASE REPORTS

Infant with *Streptococcus Bovis* Meningitis*

JEREMIAS L. MURILLO, M.D., JULES A. TITELBAUM, M.D.,
JAIME MARTINEZ, Newark

A seven-week-old infant developed meningitis due to *Streptococcus bovis* which is an uncommon pathogen in this age group. The initial presentation of diarrhea points to the gastrointestinal tract as the portal of entry as suggested in the adult literature.

Although group B *Streptococcus* firmly is established as the most common pathogen in neonatal septicemia and meningitis, streptococci belonging to the other Lancefield groups have been reported as significant pathogens in the neonatal period.¹⁻⁴ Of these, group D streptococcus is one of the well-recognized pathogens in newborn infections.⁴⁻⁷ These infections predominantly have been due to enterococci. But recently, there is increasing recognition of the non-enterococcus, *Streptococcus bovis* as an important pathogen in the newborn period.⁷ Infections caused by *Streptococcus bovis* have been described with respiratory distress resembling the early-onset disease caused by group B streptococcus.⁸⁻¹⁰ This case report describes a late-onset *Streptococcus bovis* meningitis in a seven-week-old infant who initially presented with vomiting and diarrhea.

CASE REPORT

A seven-week-old female presented with a four-day history of vomiting and diarrhea. She was a 6 lb. 14 oz. product of a full-term uncomplicated pregnancy. She was delivered vaginally by low forceps because of prolonged labor and premature rupture of membranes. She apparently was well until four days prior to admission when she started vomiting and was noted to have loose, watery stools. She progressively became dehydrated and was admitted to a local hospital for evaluation. Upon admission, she was noted to be moderately

dehydrated and to have metabolic acidosis. A lumbar puncture was done and the CSF revealed the following: 44 WBC/mm³ with 46% polys, 113 RBC/mm³ with normal CSF glucose and protein. No antibiotics were given and she was transferred to NBIMC for further management. Physical examination on admission revealed an irritable infant with the following vital signs: T 100.4°F, PR 180/min, RR 50/min, BP 80 mmHg systolic. The skin appeared mottled. The anterior fontanelle was open and flat. The eyes were deviated to the left. The neck was supple. The rest of the physical exam was unremarkable. Complete blood count on admission revealed the following: Hgb 9.1, Hct 26.8, WBC 2.6 with a differential of 45% segs, 7% bands, 41% lymphs and 7% monos. Urinalysis was unremarkable. Serum electrolytes revealed the following: Na 142, K 4.9, Cl 115, CO₂ 8. BUN was 12 mg/dl. A spinal tap was repeated which showed the following: WBC 756/mm³ with 82% polys, 18% monos, RBC 144/mm³. CSF protein was 222 mg/dl and CSF glucose was 63 mg/dl with a blood glucose of 127 mg/dl. CSF gram stain was negative. The patient initially was treated with ampicillin 300 mg/kg/24 hours in six divided doses, chloramphenicol 100 mg/kg/24 hours in four divided doses and gentamicin 5 mg/kg/24 hours in three divided

*This case report is from the Department of Pediatrics, Newark Beth Israel Medical Center and the College of Medicine and Dentistry of New Jersey (Newark). Correspondence may be addressed to Dr. Murillo at the Medical Center, 201 Lyons Avenue, Newark, NJ 07112.

doses. The CSF culture grew an alpha strep in 24 hours. This was identified as a *Streptococcus bovis* with the following characteristics: bile esculin positive, 6.5% NaCl broth negative and lactose positive. Chloramphenicol and gentamicin were promptly discontinued. She deferviced on the fourth day and did clinically well thereafter. She completed a 14-day course of ampicillin and was discharged on the 19th hospital day. CT scan, vision and hearing tests were normal prior to discharge.

DISCUSSION

In 1933, Lancefield reported a method of grouping hemolytic streptococci according to the presence of a group-specific polysaccharide found in the cell wall of the organism.¹¹ There are approximately eighteen serologic groups that can be identified on the basis of this cell wall antigen. The group D Streptococcal (GDS) antigen is differentiated from the other streptococcal groups by the presence of a glycerol teichoic acid containing glucose D-alanine.¹² GDS may give either an alpha, beta or gamma type hemolysis on blood agar and this provides little value in identification or speciation.¹³ GDS can be presumptively identified by a positive bile esculin hydrolysis test and can be subdivided according to Deibel's criteria into enterococcus and nonenterococcus.¹⁴ The enterococci have the ability to grow in 6.5% NaCl broth at pH 9.6 at 10°C and can withstand heating at 60°C for thirty minutes while the nonenterococci will not grow in 6.5% NaCl broth. The members of the enterococcal subgroup consists of *S. bovis* and *S. equinus*. *S. equinus* has not been identified as a human pathogen and is distinguished from *S. bovis* by the inability to produce acid in lactose broth or grow in litmus milk.¹⁵

As a result of the availability in differentiating nonenterococcal from enterococcal species in the laboratory, *S. bovis* increasingly has been recognized as an important cause of newborn infection. Buchino *et al.* reviewed 13 cases of neonatal sepsis and meningitis due to group D streptococci during a seven-year period from 1970 to 1976 and found four cases due to nonenterococcus.¹⁶ Bavikatte *et al.* also reviewed their experience with neonatal group D streptococcal septicemia and found that two out of eleven cases were caused by *S. bovis*.¹⁰ In reviewing 55 cases of systemic streptococcal infection in infants less than six weeks of age, Parker reported six *S. bovis* cases out of nine group D streptococcal infections.⁷

Recent reports have described a fulminant neonatal septicemia due to *S. bovis* with a clinical presentation that resembles closely the early-onset group B streptococcal sepsis.^{8,9} These infants developed respiratory distress and septic shock during the first 24 hours of life. There was no associated diarrhea or vomiting observed in these cases. Two infants had positive CSF cultures.

In contrast to these cases, we describe a delayed onset of *S. bovis* meningitis in a seven-week-old infant who presented mainly with vomiting and diarrhea. The perinatal period was uneventful except for premature rupture of membranes followed by a low forceps delivery. There was no respiratory difficulty at birth and the infant was completely

asymptomatic until seven weeks later. Bavikatte suggested that infants who developed late-onset infection were nosocomially transmitted.¹⁰ However, the present case did not have a history of prolonged nursery stay. Since vomiting and diarrhea was the presenting symptom in our case, it seems reasonable to assume that the gastrointestinal tract could be the portal of entry for organisms as suggested in the adult literature.¹⁶

SUMMARY

Streptococcus bovis, a non-enterococcal group D streptococci, is an uncommon pathogen in the newborn period. Of the few cases that have been described in neonates, the clinical presentation has been in the form of respiratory distress resembling the early onset disease of group B streptococci. A case of a seven-week-old infant with *Streptococcus bovis* meningitis is reported to illustrate an unusual presentation by an unusual organism. The infant initially presented with vomiting and diarrhea and then developed meningitis. There was no associated respiratory distress. This manner of presentation more closely resembles the adult type where *Streptococcus bovis* sepsis and/or meningitis occurs usually in association with a bowel lesion, often a neoplasm.

REFERENCES

1. McCracken GH Jr: Neonatal septicemia and meningitis. *Hosp Pract* 11:89-97, 1976.
2. Stewardson-Kreiger P and Gotoff SP: Neonatal meningitis due to group C beta hemolytic streptococcus. *J Pediatr* 90:103-104, 1977.
3. Baker, CJ: Unusual occurrences of neonatal septicemia due to group G streptococcus. *Pediatr* 53:568-569, 1974.
4. McCracken GH Jr and Shinefield HR: Changes in the pattern of neonatal septicemia and meningitis. *Am J Dis Child* 112:33-39, 1966.
5. Gluck L, Wood HF and Fousek MD: Septicemia of the newborn. *Pediatr Clin NA* 13:1131-1148, 1966.
6. Gotoff SP and Behrman RE: Neonatal septicemia. *J Pediatr* 76:142-153, 1970.
7. Parker MT: Neonatal streptococcal infections. *Postgrad Med J* 43:598-606, 1977.
8. Headings DL, Herrera A, Mazzi E *et al*: Fulminant neonatal septicemia caused by *Streptococcus bovis*. *J Pediatr* 92:282-283, 1978.
9. Alexander JB and Giacoia GP: Early onset nonenterococcal group D streptococcal infection in the newborn infant. *J Pediatr* 93:489-490, 1978.
10. Bavikatte K, Schreiner RL, Lemons JA *et al*: Group D streptococcal septicemia in the neonate. *Am J Dis Child* 133:493-496, 1979.
11. Lancefield RC: A serological differentiation of human and other groups of hemolytic streptococci. *J Exp Med* 57:571-595, 1933.
12. Joklik WK and Smith DT: *Zinsser's Microbiology*, 16th ed., New York, Appleton Century Crofts, 1976, pp. 441-443.
13. Facklam RR: Recognition of group D streptococcal species of human origin by biochemical and physiological tests. *Appl Microbiol* 23:1131-1139, 1972.
14. Deibel RH: The group D streptococci. *Bacteriol Rev* 28:330-366, 1964.
15. Buchino JJ, Ciambarella E and Light I: Systemic group D streptococcal infection in newborn infants. *Am J Dis Child* 133:270-273, 1979.
16. Murray HW and Roberts RB: *Streptococcus bovis* bacteremia and underlying gastrointestinal disease. *Arch Intern Med* 138:1097-1099, 1978.

Carcinoma Arising Out of a Primary Acquired Cholesteatoma

S. THOMAS WESTERMAN, M.D., Shrewsbury, LAWRENCE C. SYLVIA, M.D.,
ERWIN TEPPER, M.D., Long Branch*

An eleven-year followup of a 25-year-old male with carcinoma arising from a primary acquired cholesteatoma is presented. Treatment consisted of conservative surgery followed by radiation therapy. Ossicles remained intact and the facial nerve was not sacrificed. The patient is free of disease and leads a normal life with socially acceptable hearing. Theories of the origin of cholesteatomas are discussed. Present treatment modalities and results for middle-ear neoplasms are reviewed.

Middle-ear neoplasms are rare with an incidence varying from 1 per 6000 to 1 per 20,000 patients with ear disease.^{1,2} Squamous cell carcinoma, which is overwhelmingly the most prevalent histological type of middle-ear cancer, occurs predominantly in the fifth, sixth and seventh decades.³ Surgery is generally extensive and frequently results in destruction of facial nerve, ossicles, and loss of hearing.

A patient is described in whom conservative surgery yielded positive results leaving the facial nerve undamaged and the ossicles intact with good preservation of hearing.

CARE REPORT

A 25-year-old male had a chronic draining right ear since childhood. Intermittent treatment with ear drops and systemic antibiotics would stop the ear drainage for periods of several days to several months.

Examination revealed a well-nourished, well-developed male with no acute distress. The left ear drum and canal were normal. The right drum revealed a small attic perforation which was fairly well circumscribed. Thin yellowish fluid drained from the perforation while material suctioned from the area revealed cholesterol type crystals.

Audiologic analysis revealed a mild conductive hearing loss on the right side with normal hearing on the left. X-rays revealed moderately sclerotic mastoids binaurally with no evidence of cholesteatoma or bony erosion.

An atticotomy was performed in June 1969. The cholesteatoma appeared to invade the attic area causing minimal bony erosion (See Figure 1). The mastoid bone was drilled in the region of the cholesteatoma. The entire cholesteatoma was dissected down to the drum and was extirpated in toto, removing most of the Shrapnell's membrane. A postauricular incision was made and a one cm. oval diameter fascial graft was removed which was placed over the defect after the squamous epithelium was denuded circumferentially about five cm. around the perforation.

The postoperative course was uneventful and hearing returned to normal as the air-bone gap closed.

Examination of the surgical specimen showed ill-defined gray-white rubbery tissue. Histological studies demonstrated a desmoplastic fibrous matrix containing isolated isles of moderate anaplastic epithelial cells (See Figure 2). These cells were characterized by variation in size and molding. The cytoplasm of some cells appeared to resemble the prekeratin stage of squamous cells. No keratin pearls were present nor was glandular formulation. Pathological diagnosis was poorly differentiated sclerosing squamous cell carcinoma.

After consultation with the pathology department, re-

*Dr. Westerman is Assistant Professor of Otolaryngology, Hahnemann Medical College, Philadelphia; Dr. Sylvia is Director of Pathology, Monmouth Medical Center and Dr. Tepper is Director of Therapeutic Radiology at the same institution. Correspondence may be addressed to S. Thomas Westerman, M.D., 499 Broad Street, Shrewsbury, N.J. 07701.

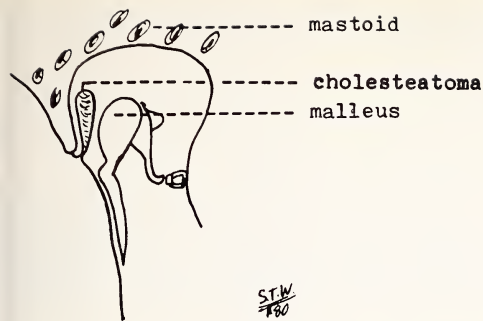


Figure 1—Drawing of Position of Cholesteatoma. Position of the primary acquired cholesteatoma containing the squamous cell carcinoma as seen in the first operation.

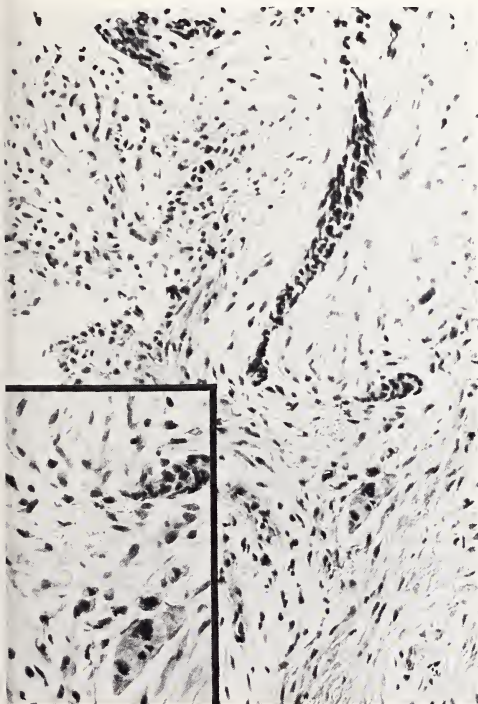


Figure 2—Histological Specimen. Histological specimen revealing desmoplastic fibrous matrix containing isolated isles of moderately anaplastic epithelial cells. Cells have variation in size and molding with the cytoplasm of some cells appearing to resemble the prekeratin state of squamous cells. Larger picture 50X with the lower left hand corner insert 160X.

operation of the patient was performed two weeks after the first procedure. A wide local excision was performed removing much more bone and the graft part of the normal drum but leaving the ossicles intact. A graft again was taken from the right post auricular area and placed over the large defect. Radiation therapy was then instituted.

Radiotherapy was accomplished utilizing the x-ray beam of the 6 MeV Varian Linear Accelerator. Treatment was performed by means of paired 55° wedged fields. The field

	Right					Left				
	500	1000	2000	4000	8000	500	1000	2000	4000	8000
9/2/69										
Air	5	5	0	5	10	5	5	0	5	10
Bone	5	5	0	5	-	5	5	0	5	-
8/2/80										
Air	10	20	25	30	25	10	10	10	10	15
Bone	15	15	20	25	-	10	10	10	10	-

Figure 3—Hearing Evaluation. Represents hearing prior to the first operation (6/69) compared to hearing eleven years later (8/80). A mild mixed loss is present on the right (operated) ear.

size in each port was 5x5 cm. A single direct lateral port and a second posterior oblique angled port were utilized. The posterior port was angled 50° relative to the direct lateral field. The high-dose volume was somewhat cone shaped conforming to the anatomy of the petrous pyramids. The dose was relatively homogenous through the area of the middle-ear cavity and proximal portion of the petrous pyramids. Some falloff medially was noted. Relatively little radiation to the underlying brain was delivered. There was a dose of perhaps 50 percent past the petrous pyramid area.

The treatment portals and dose distribution calculations all were done by hand. The high-dose volume measured approximately five cm. wide by six cm. deep according to the hand calculation. A daily dose of 200 rads to the volume of interest was treated and thus a total dose of 6000 rads was delivered in 30 sessions over 43 elapsed days.

The patient apparently tolerated the treatment quite well and there were no significant sequela. He was followed closely through a normal postoperative course and was seen approximately monthly for an 11-year period. He has mild mixed hearing loss in the right ear which causes no difficulty, although he can differentiate sounds reaching each ear. (See Figure 3) There is no residual evidence of the carcinoma or radiation effects; the drum is scarred but intact.

DISCUSSION

Chronic otitis media may be a benign chronic suppurative type or one of the more dangerous bone invading types.⁴

If necrosis of the tympanic membrane and of the middle-ear mucosa occurs as a result of acute otitis media and the perforation is marginal, squamous epithelium may migrate into the middle ear from the external meatus.⁵ Epidermis may also go into the tympanic cavity through a central type perforation.⁶ These conditions then may produce a secondary acquired cholesteatoma which is a cholesterol-filled epithelial cyst.

The second type of acquired cholesteatoma is an attic retraction cholesteatoma or primary acquired cholesteatoma. Bezold considered an attic retraction to be a result of tubal occlusion leading to retraction of Shrapnell's membrane into the attic.⁷ Here, the outer corner five layers proceed to desquamate and collect as a plug of epidermal debris. Primary acquired cholesteatomas may occur without a previous history of otitis media.⁸ Secondary acquired cholesteatomas occur in ears known to have been a seat of previous infection.

Tumarkin believed that under influence of infection the

pavement epithelium of the epitympanum may undergo metaplasia causing desquamation and rolling up of the epithelial slough into a cholesteatoma pearl.⁹ Others feel that a congenital epithelial rest causes most cases of attic cholesteatoma that occur with a perforation confined to the pars flaccida.¹⁰⁻¹²

Sade attributes its development to a complex entity found in the form of an epidermoid cyst which is seen in the attic-antral mastoid.¹³ These are usually fistulized with the external ear canal often through a rather narrow neck and/or perforation. At times they are not connected with the external ear canal and are termed congenital cholesteatomas. This communication or fistulization usually takes place through a marginal or Shrapnell perforation and mostly is accompanied by destruction of the scutum to a lesser or greater degree.

A third type of cholesteatoma is a congenital cholesteatoma. This is etiologically unconnected with chronic suppurative otitis and generally is not connected anatomically with the middle ear. It arises in an embryonic cell rest in any of the cranial bones.¹⁴

Determining the site of the origin of squamous cell carcinomas of the middle ear is difficult because the tumor frequently is located in the deep posterior canal meatus and the tympanic membrane often is perforated.¹⁵ The majority of patients present with persistent ear drainage following a chronic draining ear. Pain and bloody discharge often accompany carcinoma of the middle ear.

Late clinical manifestations include facial palsy, deafness, vertigo, tinnitus, and trismus.¹⁶ Microscopic findings may vary from well-differentiated to poorly differentiated carcinoma. Lymph node metastasis rarely occurs with these malignancies.¹⁷

The commonest site of origin of squamous cell carcinoma of the ear is the external auditory canal.¹⁸ Most squamous carcinomas are advanced by the time diagnosis is made. Lewis found one-third of the operative cases to be radiation failures.¹⁹ The remainder are treated with pure operative radiation and radical surgery which includes temporal bone removal. Cases presenting the best chance for cure are limited to the intrinsic and anatomical confines of the temporal bone.²⁰

Gacek and Goodman reviewed treatment at the Massachusetts Eye and Ear Infirmary between 1959 and 1975.²¹ Treatment modalities included partial or total temporal bone resection followed by radiation therapy, with the extent of each approach individualized.

Results of studies of the five-year mortality rate in cases of carcinoma of the middle ear range from 60 to 85 percent.²²⁻²⁴

SUMMARY

An eleven-year followup of a case of squamous cell carcinoma arising from a primary acquired cholesteatoma is presented. The patient was a 25-year-old male with chronic draining right ear since childhood. An atticotomy was performed during which time pathological diagnosis revealed poorly differentiated sclerosing squamous cell carcinoma. The patient was operated on again in two weeks. Much more

bone was removed as well as the graft part of the normal drum. Ossicles were left intact. A graft was taken from the right postauricular area and placed over the defect. Radiation therapy was instituted. A total dose of 6000 rads was delivered in 30 sessions over 43 days. The patient presently has no evidence of carcinoma. He has a mild mixed hearing loss in the right ear. The drum is scarred but intact. The facial nerve was not sacrificed.

Several theories have been presented regarding the origin of primary acquired cholesteatomas. This remains unknown. Squamous carcinomas generally are well advanced when diagnosis is made. The mortality rate ranges from 60 to 85 percent. Treatment methods include partial or total temporal bone resection followed by radiation therapy. As indicated in the present case, conservative surgery with correct indications can yield excellent results with minimal deformity.

REFERENCES

- Schall LA: Neoplasms involving middle ear. *Arch Otolaryngol* 22:548, 1935.
- Tucker WN: Cancer of the middle ear: Review of 89 cases. *Cancer* 18:642-650, 1965.
- Goodman M: Middle ear and mastoid neoplasms. *Ann Otolaryngol* 80:419, 1971.
- Shambaugh GE Jr: *Surgery of the Ear*, Second Edition. Philadelphia, Saunders, 1967.
- Mawson SR and Lubman H: *Diseases of the Ear*. Chicago, Year Book Medical Publishers, 1979.
- Shambaugh GE Jr: *Surgery of the Ear*, Second Edition. Philadelphia, Saunders, 1967.
- Bezold, F: Cholesteatom, perforation der membrana flaccida shrapnell und tubenverschluss. *Zeitschrift Ohrenh* 20:5, 1890.
- Mawson SR and Ludman H: *Diseases of the Ear*. Chicago, Yearbook Medical Publishers, 1979.
- Turmarkin A: Middle ear suppuration and cholesteatoma. *J Laryngol Otol* 53:685, 1938.
- Teed RW: Cholesteatoma verum tympani. *Arch Otolaryngol* 24:455, 1936.
- McKenzie D: Pathogeny of aural cholesteatoma. *J Larngol Otol* 46:163, 1931.
- Diamant M: *Chronic Otitis, A Critical Analysis*. New York, S Karger, 1952.
- Sade J: Pathogenesis of attic cholesteatomas. *J Royal Soc Med* 71:16, 1978.
- Mawson SR and Ludman H: *Diseases of the Ear*. Chicago, Year Book Medical Publishers, 1979.
- Goodman M: Middle ear and mastoid neoplasms. *Ann Otolaryngol* 80:419, 1971.
- Stokes HB: Primary middle-ear tumors of the temporal bone. *Arch Otolaryngol* 32:1023-1030, 1940.
- Figi FA and Hempstead BE: Malignant tumors of the middle ear and mastoid process. *Arch Otolaryngol* 37:149, 1943.
- Lewis JS: Squamous carcinoma of the ear. *Arch Otolaryngol* 97:41-42, 1973.
- Ibid.
- Hinton CD: Cancer of the middle ear and mastoid process. *J Natl Med Assoc* 66:127, 1974.
- Gacek RR and Goodman M: Management of malignancy of the temporal bone. *Laryngoscope* 87:1622, 1977.
- Marfati PT: Malignant tumors of the ear. A review of 57 cases. *Laryngoscope* 76:1591-1601, 1966.
- Sinha PP and Aziz HI: Treatment of carcinoma of the middle ear. *Therapeutic Radiol* 126:485-487, 1978.
- Lewis JS: Squamous carcinoma of the ear. *Arch Otolaryngol* 97:41, 1973.

Middle-Age Crisis: A Preventive Approach*

Middle age has been receiving an increasing amount of attention during the last few years and rightly so. It has become clear that a large number of people experience severe problems as they enter this stage of life. Neugarten and Datan found that most people have a feeling for the life cycle.¹ They are supposedly prepared to meet the transition into middle age without any significant difficulty and to exploit the positive aspect of the middle years.

However, later insights show a less optimistic picture. Recent cultural changes in our society have allowed people to talk more candidly about the difficulties they experience in adjusting to middle age. The ones who are more reticent to speak or who do not realize the nature of their inner turmoil, may show indirect signs of crisis. Some very conservative, religious or moralistic people may shock family and friends by going through a drastic change in life style. They may turn into flashy dressers, become libertine, alcoholics or irresponsible toward work and family. Others who had been healthy all their lives may begin to develop a number of psychosomatic conditions or hypochondriacal complaints, which often mask a silent depression ("Depression sine Depression").² Still others, even though remaining able to "cope," may confide to an intimate person that life has become void of meaning and full of boredom for them. Finally, there are patients with severe depression with or without concomitant paranoid symptoms, the "involutional psychoses," which sometimes lead to suicide.

The purpose of this paper is to stimulate physicians to look for incipient or hidden depression among patients in this age group in order to provide timely treatment. It is the author's hope that physicians will sponsor truly preventive programs designed to soften the impact of middle age experience for all people approaching middle age. People can be educated to anticipate the negative aspect of this transition, but they also may be prepared to take advantage of the opportunities for enrichment which this stage of life can offer. If these programs were successful, many advantages would accrue. A great deal of human suffering would be spared and society would not lose the contribution of so many people who become disabled at the peak of their productivity.

Contrary to the myth, most people, even well-adjusted individuals are not attuned to the evolution of the life cycle and so cannot adapt to middle age. Every physician has heard patients "casually" say "after fifty it's all downhill." Our culture has fostered this state of unpreparedness by promising that "you are only as old as you feel." And so, for some time, a good number of people are able to go along with the defensive denial of the changes that are taking place in their lives and in their bodies. People often make exaggerated statements such as: "Everything is A-OK . . . Feel

terrific . . . Couldn't feel any better . . ." (Younger people, who really feel "great" are seldom heard making such statements). Finally, the realization that this state of affairs is simply not true, dawns on people. The result is shock, followed by anger and depression. They feel cheated by Mother Nature who has let them down and by our culture which has fostered dreams of eternal youth.

As physicians learn to appreciate the severe inner turmoil that rages behind many of their patient's banal complaints, they should then be able to become more effective in helping them. The physician will assume the role of counselor and teacher. He will learn to approach these problems in a realistic manner by cutting through the shame people experience in confessing their fears of becoming old. He will start by telling his patients that "many of the changes in middle age constitute losses that are real and painful to all people."³ Once this problem has been recognized, the physician will be able to go a step further by instructing them how to trade these losses for the gains that one can derive from this stage of life.

Physical beauty, endurance for strenuous physical work, sexual energy, power of concentration and memory do begin to decline in middle age. The organs of special sensation also begin to atrophy. But at the same time, the individual can discover that many endeavors need much less energy than he believed were required during his younger years. This notion can best be conveyed through the use of an actual real life experience. (A physician who has reached or passed middle age can relate events from his own life).

As an example, about ten years ago, prior to my attaining middle age, I bought an antique marble artifact. It was so large and heavy that I had rented a station wagon for the day in order to transport it. Two husky young men groaned under the weight while they were loading it. When I reached home, I was greeted by my handyman who also informed me that the workers who were renovating my house had failed to show up that day. I had counted on their help to unload it quickly and return the rented vehicle the same day. John, my handyman, told me that I did not need to worry. He would do the job if I only assisted him a little. He was a slight, wiry man in his fifties. To my reaction of incredulity, he responded with a smile and said that the marble would unload itself under its own weight, and that he actually needed my help to slow it down at the opportune moment. He tied it

*Based on a presentation before the annual meeting of the American Psychiatric Association, May 12-18, 1979, Chicago. The author, Arnaldo Apolito, M.D., is clinical professor of psychiatry at New Jersey Medical School, CMDNJ, Newark. He may be addressed at 80 Undercliff Road, Montclair, NJ 07042.

with a rope and handed the other end to me. Then he proceeded to wiggle and turn the marble as though he were toying with it. He was in no hurry and seemed to enjoy himself. He asked me to pull on the rope as he was lowering the piece on a hand trolley, and there it was on its way into the house. I was relieved then and later I was very grateful for such a lesson from John.

So, the middle-aged man can learn how to distribute his energies wisely and can become more attuned to the limits his body can reach. This applies to his work, sexual activities, sports, and food intake. He has to learn the pleasure of "sipping" life rather than "gulping" it. If one's tolerance for wine has decreased, one must drink less, but one then may afford to drink finer wines.

The waning of man's sexual power can be a very agonizing realization and one of the main causes of depression. Sex is not only one of the most cherished sources of pleasure but also a reassurance that one is attractive and virile, and can preserve the love of his female partner. It is true that man in his youth is capable of an immense amount of sexual performance, but this is an obligated route for the discharge of a considerable portion of his energy. Not so with the middle-aged man. If he is in tune with his body, he will realize that the sexual drive becomes less of a painful urge with advancing age, but it can become an exquisite pleasure. So a man in his middle years has a wider choice of how to use his energy. He can deploy some through the sexual route and some via other routes of creativity. The freedom of choice in itself plus the attainment of whatever goals he has invested in, can offer him satisfactions not inferior or at time superior to sexual fulfillment.

The physician can help his patient to realize that though his brain has fewer neurons in middle age, it has a storage of knowledge and experience that allows him the privilege and the excitement to occupy a position as leader or teacher. He can say to his patients, "It's true that younger people run faster and longer in this world, but it's also true that middle-aged men run this world."

The middle-aged person tends to idealize youth, forgetting all its negative aspects and minimizing the advantages of his age. He has to be reminded how the younger years are so often tormented by feelings of inadequacy, a nagging notion of being a midget in a land of giants. The only solace of these years is often found in the fantasy that one day, the midget will grow into a giant. While the mature years destroy such an illusion, the middle-aged man also can realize that there are no giants in this world to fear and so he does not have to become one. It is no small gain to feel competent in what you are doing and not to have to struggle with the gnawing doubt of being a fraud. The acceptance of his true human nature can bring him as close as possible to that state of serenity toward which the human being is forever striving.

One of the most distressing fears the physician will hear is that the creative potential comes to an end with middle age. This is more likely to be the predicament of the woman, especially if she has not had the opportunity to bear a child. The reality of the situation is that while creating a child may be either physiologically impossible or simply unwise at that age, the middle-aged woman has the potential for a great deal of creativity in other fields. It is important that the person be encouraged to remain creative because the only alternative left is to wither and die. One of the pioneers in the study of creativity in leisure time is Alexander R. Martin from the Karen Horney School of Psychoanalysis. He has not only studied and advocated creativity in the later years

but has practiced it so very successfully, way beyond his middle age.⁵

It is true that the continued creative use of time is more feasible for people who do have an independent career than for those who are employed and are forced to retire and for women whose careers have been limited to child rearing and homemaking. Fortunately, our society is remedying this situation to a great extent. The forced retirement age has been raised and careers are being opened to women. Society has also acknowledged that the middle-aged person not only needs but has the capacity to have fun and to learn and to grow. It is important to bring these changes to the attention of the middle-aged, because the cultural attitude that prevailed during their formative years condemned such aspirations with one succinct admonition—"Act your age!"

Another problem for the aged person is to abandon his dreams of immortality and to stare at death from a closer range. This is an additional existential problem which the physician cannot erase. However, he can point out to his patient that our times allow not only a longer life, but a fuller life. He can, if he wishes, experience and accomplish in one day what used to take a number of days in the past. This possibility, as someone once reflected, if wisely exploited, can actually double or triple one's life.

Loss of physical attraction and loneliness often confront people in this age group. Unless the person has substantial inner resources to be creative and likes himself, he may need help to deal with such losses.

The review of the major problems that his patient is experiencing and of the remedies that are available will be most successful if it will lead the patient to reorient himself along a new philosophy by which to live. This is as follows: Middle age can be a fulfilling stage of life if man realizes that Mother Nature will no longer regenerate him during his sleep. The vast amount of energies that he squandered during the day will not be fully replenished during his sleep as when he was younger. He must take himself into his own hands and become his own maker. This process is described by Mandel as shifting from mid-brain to upper-brain function.⁴

In concrete terms, the middle-aged man has to learn that at this stage of life he still can have sufficient energy to live a good life if he takes proper care of his body and uses it wisely. This requires a conscious effort and may involve a certain amount of pain. A patient in his forties was complaining about the physical and mental anguish he had experienced at the beginning of his jogging. In the process he had lost twenty-five pounds and was now feeling much better physically and mentally. "It's painful," he said, "but that's what you get for twenty years of self-neglect." On the other hand, the old adage that after youth is over, one must conserve energy as much as possible in order to remain healthy, also has proved to be a fallacy. Often when one wakes up in the morning, his joints feel stiff and achy. After some activity, they become loose and painless. The same concept applies to the function of the mind. It is well known that an active mind resists aging better than an idle one.

While the previous suggestions constitute a good program of early intervention in the treatment of middle-age problems, the medical profession should study the feasibility of true prevention. By this I mean, the development of programs to prepare people to meet middle age without the sudden impact that so many experience. Reaching people before the onset of middle age would represent a great advantage. Many of us live with dreams that we have an infinite amount of time to restructure our lives. It would help

many to realize that time for change does run out eventually. Some may be able to reexamine their goals more realistically and make certain inner or outer changes before it is too late.

Potential forums to address this target population are available in businesses and industry, churches, philanthropic organizations and schools for "adult education." These institutions already have shown some interest in the problems of aging and have attempted to develop some rudimentary programs of prevention. They would probably welcome the input from professionals in the medical and psychological fields.

For the time being, the physician remains the principal source of prevention of this crisis. True that he does not have access to the population at large, but he frequently sees people who are particularly vulnerable to develop middle-age crisis. This group includes people who are experiencing real losses, either through divorce, severe illness, major surgery, loss of children or business reversals.

In the future, society specifically will develop nationwide programs of true primary prevention in childhood.⁶ This should help people to grow more attuned to the changes in their inner selves as they evolve through life from one stage into another. Probably then prevention of middle-age crisis will become obsolete. But for the time being, the programs I have outlined not only will aid the middle-aged people to deal with this stage of life but also will prepare them to face the last stage—that is, old age and then the ultimate challenge, which is death. The only secret of facing death is a successful life. The person who has partaken of the banquet of life, the Roman poet Horace said, will leave it like the guest who leaves the table of his host "satiatus" (satisfied).

SUMMARY

The number of people who experience middle-age crisis, a syndrome which often goes unrecognized, is increasing. Depression with the classical symptomatology and paranoid states are only a small fraction, even though the most severe expressions, of this turmoil. Most often the psychological changes manifest themselves as a change in personality, as hypochondriasis or as psychosomatic disorders ("Depression sine Depression"). Human suffering, disruption of families and loss of productivity are severe among this age group.

Early detection and treatment are important but programs aimed at reducing the incidence of these syndromes should be developed. Through education, the individual approaching middle age can be prepared to accept the unavoidable losses of this stage of life. He also can learn about the potential fulfillment and self-realization that one can derive from middle age.

Arnaldo Apolito, M.D.

REFERENCES

- ¹Neugarten BL, Datan N, in Arieti S (ed): *The Middle Years, The American Handbook of Psychiatry*, Vol. I. New York, Basic Books, 1974, chapter 29.
- ²Apolito A.: Severe depression resembling severe physical illness. *J Med Soc NJ*, 74:943-946, 1977.
- ³McCrane EG: Neurotic problems in middle age. *Psychomatic*, 19:106-107, 1976.
- ⁴Mandel A: *Coming of Middle Age*, New York, Summit Books, 1977.
- ⁵Martin AR: Fear of relaxation and the use of leisure time. *Am J Psychoanal*, 11:42-50.
- ⁶Apolito A: Primary prevention: A breakthrough in sight. *Am J Psychoanal* 38: 121-127, 1978.

Notes on a Bygone Practice in a North African Country*

ALDO A. CALO, M.D., Princeton

The professional experience of an internist-cardiologist in a former North African French protectorate is described, as are aspects of medicine practiced by European physicians of the previous two generations and the incidence of coronary artery disease in different ethnic and social groups of the population.

During the first half of my professional career, from 1934 to 1957, I practiced in a multinational, multicultural, and multireligious community. In a country where, and at a time when house calls were as routine as office visits, I had ample opportunities, as a physician, to observe the daily life of the different ethnic and religious groups and of social classes as diverse as the ruling Tunisian dynasty and the manual worker's family.

At the time, my experience did not appear particularly remarkable to me; it was the same for my father, three uncles, five cousins, my wife's grandfather, and many friends who were practicing in the same environment. Now, a quarter to half a century later, and with a very different perspective, several aspects of this practice appear quite unusual and worth mention. Therefore, I gladly accepted the editor's suggestion to put them in writing for publication.

Most customs I am going to describe were those of the 1934-1957 period which I observed personally when I was practicing in Tunisia. Other customs go back to the first three decades of this century. They were reported to me by my father and by other physicians. A few more customs were observed in the second half of the nineteenth century; they were related to my predecessors by the previous generation of physicians and then to me. Of course, over the years, many changes have taken place and, in 1981, many habits and attitudes are very different. Finally, as I am going to dwell mostly on unusual or strange (for a Western reader) usages,

I do not want to give the impression that these were the only ones I was exposed to. In many ways, life in Tunis was not different from that of any European city.

CARDIOLOGIST TO THE ROYAL FAMILY

A very few years after I first opened my office, the Bey (hereditary ruler) of Tunisia had an acute myocardial infarction. I was called to his palace to consult with his attending physicians and to record an electrocardiogram. My portable electrocardiograph was operated by a set of automobile batteries and quite heavy, but I had no difficulty in having it installed at the bedside. The tracing was a photographic one which I had to bring back to my office for development. The clinical diagnosis was confirmed and the treatment was started, including rest, sedation and a nitroglycerin syrup. That was all we could do in the mid-1930s.

Prognosis was very important in a political and dynastic setting. Following a tradition which still is observed in Saudi Arabia and in other Arabic countries, the heir apparent to the throne was not the sovereign's eldest son, but the oldest prince in the family. Because of his usually advanced age, the

*A native of Tunisia, Dr. Calo earned his medical degree in Rome and, after completing graduate training in internal medicine and cardiology in Paris, returned to Tunisia to practice until emigrating to the United States in 1957. Here most of his professional activity was in Bristol, Pennsylvania. His medical publications include two books and 86 papers. He now is retired and living in Princeton. Dr. Calo may be addressed at 290 Hamilton Avenue, Princeton, NJ 08540.

his apparent might well die before the reigning Bey and this also could happen to the next heir apparent and so forth. This dynastic law thus often resulted in bringing to the throne a very distant cousin, usually little known, possibly relatively impoverished and unprepared for high office. It was, therefore, essential and urgent for the French government and for the palace staff to start briefing him and to seek his cooperation and support.

In the mid to late thirties, cardiology was what it was and electrocardiograms included three leads only. The only way to make a prognosis, beside the clinical picture, was on statistical grounds. According to a study just published in France at the time, the Bey's tracing was associated with an 85 percent probability of imminent death. This indeed occurred as expected and my prophetic skill was then well established.

Several years later, I was asked to examine and treat one of the princesses, the youngest daughter of the reigning Bey. After my initial visit, I reported to her father, in his private quarters, that she had a mitral stenosis at an early stage of failure. I had to speak Arabic, which I knew only imperfectly, although the Bey understood French well. Arabic was the language of the land and French was the language of the colonial power. At the end of the interview, the Bey accompanied me to the palace door with his aide-de-camp and the latter asked me, as it was customary, about my fee. I answered that I considered it a great honor to be called to take care of the Bey's daughter and that I would accept no compensation. After the next visit, the aide-de-camp gave me a purse with a certain number of gold and silver coins minted to the Bey's name. Although the legal currency was French, the Bey was allowed, as the nominal sovereign, to mint every year a certain amount of his own money which, according to the Koran's ban on graven images, did not bear his effigy. These were not coins, the aide-de-camp told me, but tokens from the Bey's appreciation, bearing his name.

As time passed, I was appointed cardiologist to the Bey's family (figure 1) and became a regular visitor at the palace, which was not only a sovereign's residence, but a Moslem home. No man, except for father, uncles and brothers, was allowed to enter a traditional Moslem's house unannounced as he might see the women unveiled. The average middle to low-class house (figure 2) opened to the street (S) through a hall (H) where the visitor would enter and knock at a door leading to an antechamber (AC). If there were no men in the house to answer, a woman would clap her hands twice to ask who was there. Even a woman's voice was not supposed to be heard by a male stranger to the family. If the visitor, either a female or a male relative, were allowed in, the door between the entrance hall and the antechamber would be opened and she or he would enter the secluded patio (P) where the other rooms (R) opened and where much of the daily activity was taking place. Quite often there were no windows opening to the street. The street door and the antechamber door were often left unlocked as no strange man would dare to enter the

house and risk seeing an unveiled woman. This was regarded as a great crime, severely punishable in older times by law and by the woman's father, brother or husband.

TWO LOAVES OF BREAD, A LAMB, ET CETERA

The Palace, as I said, was not only the sovereign's residence, but a Moslem's home; however, since physicians in Tunisia were held in high esteem and considered as family members, I was allowed to enter unannounced past the sentinels at the main gate (figure 3) and through the different doors, from room to room, in the same way as in ordinary houses. Moreover, as the Bey's physician and as a member of his household, I symbolically shared his food by being entitled to two loaves of bread a day from his bakery. For several years I did not take advantage of this custom but, during the German occupation, from November 1943 to May 1944, two daily loaves of bread were helpful in overcoming food scarcity and rationing.

This thoughtfulness showed in many other circumstances. Every year, at Passover, I received a butchered lamb from the Bey's livestock. Incidentally, another lamb was once sent to me by another patient on the same occasion. My office was on the first floor and my residence on the second floor of the same house. One day, during office hours, I heard a great noise and commotion and my receptionist hurriedly entered my consultation room to inform me that a live lamb was being delivered to the second floor. One man was pulling it up the stairs and two men were pushing it with much confusion, bleating and shouting. I had to ask them to take the lamb back and to return it butchered and quartered, which was properly done.

There was an old Jewish tradition in Tunisia to give a needy family on the eve of Yom Kippur as many chickens as there were members in the donor's family. Each year, at the appointed time, I would receive from the palace ten chickens—twice as many as people in our family—to give away according to this custom.

Following the example of the French King, Louis the 16th, whose hobby was watchmaking, the Bey was very fond of watches and clocks of which there were many in his palace. They were antique and contemporary, large and small, fancy and plain. The Bey gave every physician of his household a gold watch every year and the obstetrician one for each newborn grandchild. On one occasion a daughter presented him with twin grandchildren and he gave the obstetrician two watches at the same time. As his cardiologist, I received several watches, some of which were very unusual. One, when stopped after fifteen seconds while counting the pulse

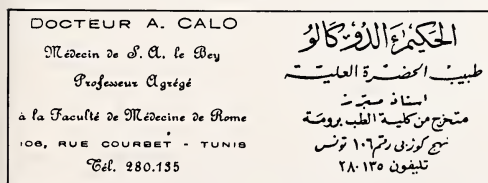


Figure 1

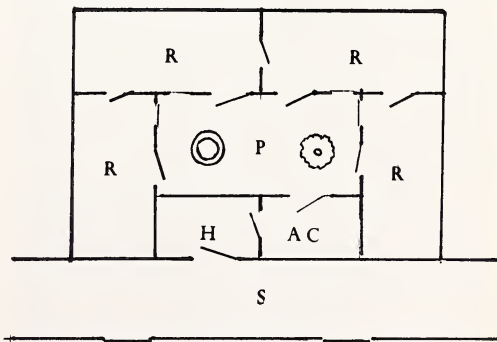


Figure 2



Figure 3

would tell the heart rate; another had a chime for each hour, half hour and quarter hour; still another bore Arabic greetings engraved in its case. Among other gifts from the Bey on different occasions were two pieces of jewelry to my wife, each after she delivered a son.

This generosity was a tradition in the Bey's dynasty. On several occasions, one of my uncles, who was physician to the palace at the turn of the century (these were more affluent times) was given emerald rings, pendants or brooches for his wife. A friend and colleague showed me a gold surgical kit for otorhinolaryngology given in the mid-19th century to his great-grand uncle.

The consideration and trust shown to me by the ruling family also was manifested by less prominent people. At New Year's Eve, physicians were given all kinds of presents by patients who already were paying medical fees from their own pockets. There was no welfare system and no medical insurance and it certainly appeared to them that their debt of gratitude could not be satisfied with money alone.

PREDESTINATION AND FATALISM

As the Princess' condition deteriorated I advised her father that commissurotomy was indicated (this was in the early mid-fifties) and that a leading cardiologist from Paris should be called on consultation. The physician came and agreed. However, the Bey, the spiritual as well as political leader of his country, decided against surgery, feeling that an organ created by God should not be tampered with by human hands. The Princess died a few years later.

This fatalism was noticeable in many other situations. A certain patient failed to keep his appointment with me; when he came unexpected the next day, he told me that it was written he would go to the movies rather than to come to my office, and he had done so. A 20-year-old woman with decompensated mitral stenosis already had four children. When I warned her middle-aged husband against further pregnancies, he answered that he would take no anticonceptual measure as, at any rate, her fate could not be

changed. His wife became pregnant and she died before delivery from acute pulmonary edema.

FOOT MASSAGE AND OFFICE VISITS

In the evening, the Bey used to withdraw with a few members of his household, including two or three musicians and his dwarf jester, to a small private room to relax and to talk with much informality. It was at that time of the day that he would have what was new for me and, I suppose, unheard of by most western people—foot massage. While he was conversing, a masseur would gently manipulate his feet, a procedure which I can attest to is very relaxing. At the present time, foot massage is being advertised here, but with a machine which, of course, lacks the personal touch, the warmth, the adaptability and the gentleness of human hands.

Both father and daughter occasionally needed electrocardiograms. For a certain period of time, immediately after the German occupation, I had no portable electrocardiograph, as mine had been destroyed by fire. No replacement was available in the entire country and it was not possible to order one from still occupied Europe. However, I had an old machine, almost as big as a billiard table, which could not be brought to the palace. Because of this, the Bey came on a few occasions to my office with his retinue, including relatives and bedecked generals. The street would be closed to the traffic and passers-by would come as near as permitted.

THE GERMAN OCCUPATION

For many years I treated a Moslem girl of the lower-middle class, whose family occasionally sent me eggs, vegetables, and oranges. These became very helpful during the German occupation, when food was rationed and people had to stand in line for hours to get even a pound of carrots. During this period of severe scarcity, these gifts increased instead of decreasing or stopping, as this family had more opportunity than mine to obtain food from the country. A few months before the Germans surrendered to the Allies and when they had started rounding up Jews and building crematories, this Moslem family offered to hide us in their home, well knowing what would happen to them if this was discovered. A similar offer was made to us by two Catholic patients of mine, a French colonel and an Italian storekeeper. Both assisted us in storing some valuables in their homes, and the former even helped me to carry a heavy trunk to his fourth-story apartment across the street, in the middle of the night to avoid detection.

HOSPITAL CARE

With no welfare system and no medical insurance, how could the needy cope with illness? They did so through hospitals and physicians. During my time, there were in Tunis four civilian hospitals, all of them free to the public, and a French Army hospital. Of the four civilian hospitals, one had been established in the 19th century by the Italian community and then gradually enlarged and improved to become a modern, large, general hospital. The other three hospitals were run by the French-Tunisian administration. One was for the French population and the others for the Tunisian population. This distinction was mostly discriminatory, although officially it was said to be due to practical reasons such as the language spoken by the staff (Arabic or French) and the different eating, bedding and other habits of the patients. Until the turn of the century there was also a Jewish hospital where patients could eat

kosher food, observe the Sabbath and follow the other tenets of their religion. It was established by the Jewish community well before Tunisia became a French protectorate and eventually it was incorporated into the French hospital.

Physicians spent three hours in the hospital every day, usually from 7 to 10, and were on call for the rest of the day, at night and on Sundays and holidays. They were associated with the hospital of their ethnic group, but I attended, at different times and in different capacities, all of them, including the French Army Hospital. Admission to the staff was through competitive examination. There was no salary and no compensation whatsoever, not even reimbursement for transportation. When we were on 24-hour duty, we were given free room and board.

The division of hospitals according to the national origin of their patients was the residue of a very much broader separation between the different agencies, authorities, administrative bodies, and public offices which regulated the life of the European population until the late 19th century. Until then, and for historical reasons which would take too long to explain here, there were in Tunisia, Italian, French, British, Austrian, and other-nationality hospitals, schools, post-offices and courts. In 1896, non-French courts and post-offices were closed and only Italy was allowed to have a hospital and a complete school system. Until the mid 1950's, nationality was transmitted from generation to generation and not acquired through "jus soli" when born in the country. This explains how my great-grandfather settled in Tunis around 1839 and still my children were born Italian more than one hundred years later.

OFFICE CARE

After this digression, useful to understand the complex background of medical practice in Tunisia in bygone years, we shall return to the care of the needy.

Until the second or third decade of this century, a physician had two offices: one in the slums and one in the rich or relatively rich European district. The former was very simply set—an examination/consultation room with desk, table, a few chairs, the necessary instruments and books, and two waiting rooms, one for women and children, the other one for men, each furnished with a few benches. Walls were whitewashed and floors were made of cement or tiles. The other office was usually a part of the physician's home. His living room was the waiting room and there were one or two rooms set apart for his practice.

My father specialized in venereal diseases. He was the first in Tunisia, around 1903, to use salvarsan for the treatment of syphilis. A quantity of the drug in powder form was dissolved in 500 cc of distilled water and the entire solution was injected intravenously over a very long period of time. I still remember the huge, complicated apparatus to distill tap water. For the treatment of gonorrhea, large amounts of a permanganate solution were repeatedly injected into the bladder over a few weeks period. Of course, during office hours nobody in the family was allowed to enter the living-waiting room and, whenever the doorbell rang, everyone had to stay clear of the hallway, lest he should recognize a patient. I have not forgotten the general embarrassment when I bumped into a cousin of mine, several years older than I.

Tuberculosis, cancer and mental illness, together with venereal disease, were regarded as so shameful that they had to be carefully concealed, especially when there was an unmarried daughter in the family; the girl would have less

chance of finding a husband if a parent or relative had been known to be affected by one of these illnesses. The first physician specializing in tuberculosis had to open his office—this was around 1945—in a building where there was a well-known dressmaker as, if a marriageable girl was seen to enter the street door, it would be presumed she was going to order a dress.

In earlier times, house calls were made by horse and carriage in the "European City" and on foot in the adjacent "Arabian City" where some streets were so narrow that one could not walk with an open umbrella. In this district, physicians used to follow a carefully planned itinerary to avoid retracing their steps. They were preceded by an "interpreter" who was at the same time coachman, medical assistant, and instrument carrier. He was seldom used as a real interpreter, as most European physicians spoke Arabic well. Another of the interpreter's duties was to give advance notice of the doctor's approach so that the patient's house, the patient himself and his family would be ready on his arrival.

Fees in the "Arabic City," which included the Jewish ghetto, were usually lower than in the "European City." No fee was charged for people living in small, dilapidated and poorly furnished houses, on the assumption that they were more or less destitute. However, this was not always true. For years I treated a young boy who was living with his parents and several siblings in a two-room slum apartment. His father, as I discovered later, was a well-to-do butcher who owned two or three shops in town, but he was born and raised in that special neighborhood and had no inclination to move. One man used to go to physicians' offices unshaven and almost in rags; consequently he was charged very little or nothing until he was found to be a wealthy landlord. When this was discovered, he would change physician. He was my patient for a while.

CORONARY ARTERY DISEASE IN TUNISIA

To end on a less anecdotal note, I wish to mention some observations I made and published a quarter of a century ago on the incidence of coronary artery disease in Tunisia.¹ Because she was at the same time an integral part of the Arab world and geographically very close to Europe and because she had been subjected to repeated invasions and migrations over a two thousand year period, that country was the crossroads of three civilizations. Her population included Moslems, Christians, and Jews. Each of these groups showed a wide spectrum of social and cultural differences. Most Moslems, whether they resided in the country or in the cities, lived a multi-century traditional life, often characterized by scarcity and arduous work, but emotionally tranquil. A small number of those living in the cities were westernized. They attended French schools and universities and were professionals, industrialists, merchants or civil servants. Christians were mostly Catholics, either French or Italian. There was a small number of Maltese, Spaniards, and Greeks. Jews included two groups. Most of them had settled in North Africa after their 1492 expulsion from Spain and had been Tunisian subjects (and not citizens) for four and a half centuries. After 1881, when France imposed her rule upon Tunisia, the large majority of them adopted French culture and ways of life. A small number of Jews came to Tunisia from Italy and France during the 19th century. They already were completely westernized and culturally different from most of their Tunisian coreligionists.

At the time of my study, there was no doubt that the

Religious, Ethnic, and Cultural Division of the Tunisian Population				
Moslems		Christians		Jews
Traditional	Westernized	Westerners	Westernized	Traditional

incidence of coronary artery disease was far greater in Europeans and in westernized Moslems and Jews than in traditional Jews or Moslems. Four factors were considered in attempting to account for this difference: "race," diet, tobacco smoking and emotional stress.

"Race" was found to play no role. As we shall see later, Tunisian Jews and Tunisian Moslems, both of semitic origin, exhibited the same incidence of coronary artery disease as Europeans (Christians and Jews), when subjected to the same emotional stress and they showed a much lower incidence when they were not.

It is a matter of common knowledge that eating habits are the last to change—well after dress and language—when people are in cultural transition. Change in eating habits usually takes longer than a generation and this can be seen easily in the different ethnic groups of the United States. In the same way, westernized Tunisians, Moslems and Jews, used to follow the same traditional diet as their parents and grandparents. However, in contrast to them, they would smoke as much as Europeans. Therefore, it appeared there was no cause-effect relationship between diet and coronary artery disease, whereas such a relationship could not be ruled out in the case of tobacco smoking.

The fourth factor, differing exposure to emotional stress, appeared to be the determining factor in this morbidity. Europeans and westernized Tunisian Moslems and Jews who were striving for success, whether economic or social, were subject to continuous psychic pressure, anxiety and frustration. I saw two overworked Moslem physicians die in their early forties from acute myocardial infarction, one after performing a long operation and the other during a heated argument with a French colleague who escaped with an acute pulmonary edema. Another example is that of two relatively young Moslem civil servants who suffered heart attacks when confronted by an angry mob.

Similar accidents were not infrequent among westernized Tunisian Jews subject to a similar degree of stress. On the other hand, not a single case of coronary artery disease in traditional Jews or Moslems ever came to my notice.

In the southern part of the country, there is an island, Djerba, known since Homeric times as the land of the Lotus-Eaters. Those who ate the fruit of the lotus became indolent, dreamy and forgetful of reality and responsibility. There

Ulysses, returning to Ithaca, forgot for some time, Penelope and his native land. In that blessed isle, cut off from the rest of Tunisia by sea and desert, still survived the oldest Jewish congregation in the world, dating back more than 2,000 years. There, the same patriarchal life was lived as in biblical times; people were content with their meager resources and their social and religious activities and had no coronary artery disease.

A Catholic-French landowner and a patient of mine, created a large palm-tree plantation from sand at the edge of the Sahara Desert by thirty years of hard physical and emotional work. At the time I first made his acquaintance, several hundred men, all Moslems, worked six days a week for him. When, some years later, a law passed, substantially increasing their minimum wages, they decided to work only four days a week, which permitted them to earn, with less effort, the same amount as before. These people spent their free time under a tree sipping a very strong, mint-flavored tea and talking or playing checkers. To my knowledge, none of them suffered coronary artery disease, but it was their employer whom I was treating for this illness.

Similar findings were reported in the two other French North African countries, Algeria and Morocco. They also agree with the well-known higher occurrence of coronary artery disease when Yemenite Jews emigrated to Israel and when Indonesians, Melanesians, Japanese and Eskimos went to live in Europe or came to the United States.²

Such is the price one pays for "civilization."

SUMMARY

The professional experience of an internist-cardiologist in a former North-African French protectorate is described. In addition to this first-hand recollection, which covers the 1934-1957 period, some aspects of medicine as it was practiced by the European physicians of the previous two generations are reported.

The first part of this essay deals, within the context of medical practice, with local customs and beliefs as they were until a quarter of a century ago, and with personal anecdotes. The second and final part is a discussion of the incidence of coronary artery disease in the different ethnic and social groups of the population and of the role played in this incidence by emotional stress.

¹Calo A: Notes sur la diffusion de l'atherome coronarien en Tunisie. *Communications au XXXe Congrès Français de Médecine, Alger, 1955*. Paris, Masson et Co, 1957

²Calo A: L'ateroma, malattia della civiltà, *Cardiologia Pratica Firenze* 7:1956.

Modern Views of Vitamin D

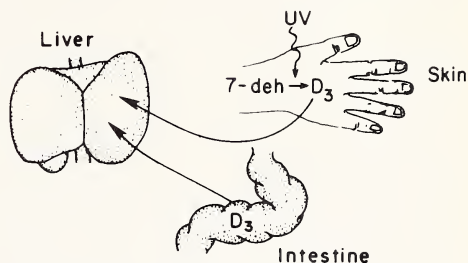
HECTOR F. DeLUCA, Ph.D., Madison, WI*

Vitamin D is unique among the vitamins in several respects. First, it is a steroid and its main active form acts in a manner quite similar to that of other steroid hormones. Second, it is not a dietary requirement when the organisms are subjected to sufficient amounts of ultraviolet light originating from the sun. Third, it is the only vitamin known to be converted to a hormonal form. The full realization of these unique features of vitamin D has led to an explosion of investigation resulting in rapid advances in our understanding of its metabolism and mechanism of action. In addition, these investigations have led to the rapid application of the active forms of vitamin D and our knowledge of the vitamin D endocrine system to the understanding and treatment of metabolic bone disease. This brief review will provide the basic information on the vitamin D endocrine system as it is visualized at the present time and the disturbances in that system in some disease states.

METABOLISM OF VITAMIN D₃

Vitamin D₃ originates from two sources (see Figure 1). It is synthesized in skin under normal conditions. When an organism is subjected to ultraviolet light, an intermediate in the biogenesis of cholesterol, 7-dehydrocholesterol, is converted to previtamin D₃ which then equilibrates slowly to vitamin D₃. The vitamin is then bound to the plasma transport protein and transferred to the liver where it enters the metabolic sequence. Alternatively, vitamin D₃ is absorbed from the small intestine, from the diet or food supplements, being found only in such sources as liver or fortified foods such as milk. Unfortified milk has about 40 I.U./liter of vitamin D activity despite claims of super active forms of vitamin D in milk. Vitamin D, being lipid soluble, is absorbed primarily with lipids through the lacteal system. Vitamin D₃ from either source is rapidly cleared by the liver.

Vitamin D₃ must be metabolically activated before function (Figure 1). The first activation step occurs primarily, but not exclusively, in the liver where it is converted to 25-hydroxyvitamin D₃ (calcidiol) which is the major circulating form of vitamin D₃. Calcidiol also is not active at physiologic concentrations but must be activated further before function. This activation in nonpregnant animals takes place exclusively in the proximal tubule of the kidney where a 1 α -hydroxyl group is installed on the molecule giving rise to the final active form of the vitamin D hormone, 1 α , 25-dihydroxyvitamin D₃ or calcitriol (see Figure 1). This hormonal form of vitamin D (calcitriol) is then transported to the intestine, bone, kidney and perhaps other sites, where it initiates the actions of vitamin D. These are (a) intestinal absorption of calcium and phosphorus, (b) the mobilization of calcium from the bone fluid compartment and (c) renal reabsorption of calcium. This results in an elevation of plasma calcium and phosphorus to levels that will support normal mineralization of bone and neuromuscular activity.



Activation and Functions of Vitamin D₃

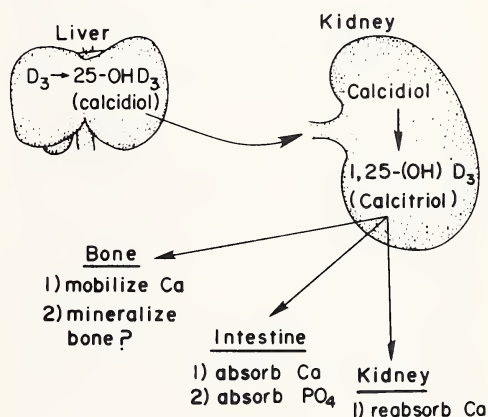


Figure 1—Vitamin D₃ Synthesis

There may be an additional action of one of the vitamin D compounds directly on the mineralization process in the bone. This, however, has not yet been established firmly though clinical evidence is suggestive.

In addition to the metabolic activation of vitamin D to calcitriol, other pathways of vitamin D metabolism are known, but their function remains unknown or controversial. Vitamin D and its metabolites, including calcitriol, are excreted into the feces via the bile with as much as 60 to 80 percent of an injected dose appearing in this excretory route. The exact chemical nature of the excretory forms is not known.

In keeping with its hormonal nature, the production of calcitriol is strongly feedback regulated. Perhaps the most

*Reprinted with permission of Contemporary Nutrition 6:2 (Feb) 1981, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. DeLuca is Professor and Chairman, Department of Biochemistry, University of Wisconsin.

important regulating factor is the blood calcium level. Low blood calcium stimulates the parathyroid glands to secrete the peptide hormone, parathyroid hormone. Parathyroid hormone is transported to the kidney where, along with its other functions, it stimulates the 25-hydroxyvitamin D₃-1α-hydroxylase that converts calcidiol to calcitriol. Together with the parathyroid hormone, calcitriol stimulates the mobilization of calcium from bone and the renal reabsorption of calcium in the distal tubule. Calcitriol by itself stimulates the intestine to absorb calcium. Calcium from these three sources then is transported into the plasma where the blood calcium level rises to the normal range, thus suppressing the parathyroid glands and thereby shutting down production of calcitriol. It is evident that the vitamin D-based hormonal system is extremely important in the regulation of the blood calcium levels.

It might be expected that under conditions where there are great demands for calcium there is a marked stimulation of calcitriol production. This is clearly the case under conditions of pregnancy and lactation when great demands for calcium are made. In man and animals, calcitriol levels in the blood rise sharply during the terminal stages of pregnancy and rise even more sharply during the periods of lactation. This correlates with both the mobilization of calcium from bone and increased intestinal absorption of calcium. The vitamin D endocrine system therefore reacts in a positive manner to provide calcium under conditions where it is drastically needed. The exact signal involved in stimulating the calcitriol production during pregnancy and lactation is not known although it has been suggested that prolactin may be involved.

A major stimulus of the calcitriol levels in blood is the inorganic phosphorus level. Low blood phosphorus brings about marked elevations of plasma calcitriol levels in both animals and man which markedly stimulates intestinal absorption of phosphorus as well as calcium and also markedly stimulates the mobilization of phosphorus from bone. Thus calcitriol can be regarded as a phosphate-mobilizing hormone as well as a calcium-mobilizing hormone. It is unknown how low blood phosphorus causes the marked elevations in plasma calcitriol levels, although there is no doubt that some of this is the result of a stimulation of the 25-hydroxyvitamin D-1α-hydroxylase system.

CELLULAR AND MOLECULAR MECHANISM OF ACTION OF CALCITRIOL

Concentrating on the well-recognized role of calcitriol in stimulating the transfer of calcium and phosphorus across the intestinal mucosa, some idea of how calcitriol functions at the cellular and molecular level can be realized. Calcitriol is transported to the target cells. In the case of the intestine, this is the mucosal villus cell. Here it binds with a specific cytosolic receptor (Figure 2). This receptor-bound calcitriol is transferred into the nucleus where it initiates a series of events that cause the transcription of specific genetic information. This information, in the form of messenger RNA, makes its appearance in the cytosol and codes for specific calcium and phosphorus transport proteins. The transport proteins are then transferred to the brush border membrane surface where calcium and phosphorus entry into the cell is facilitated. The calcium and phosphorus is transferred to the basal lateral membrane where it is expelled into the extracellular fluid compartment. Much remains to be learned concerning the molecular mechanism of calcitriol and a great

deal of new information can be expected in the next decade.

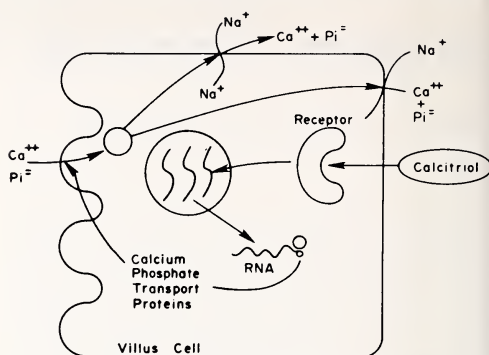


Figure 2—Mechanism of Calcitriol in Intestine

VITAMIN D-RELATED DISEASES

Several disease states are now known where there is a disturbance in the vitamin D system. Space permits only cursory mention of some of the more obvious ones.

RENAL OSTEODYSTROPHY

Patients who have lost renal function and who have glomerular filtration rates below 20 ml/min have virtually unmeasurable levels of calcitriol in their blood because the organ responsible for biogenesis of the vitamin D hormone is inoperable. This condition is largely responsible for bone degeneration in patients with kidney failure. This disorder is treated successfully in 90 percent of the cases with calcitriol or an analog thereof.

HYPOPARATHYROIDISM

Patients without functional parathyroid glands cannot "sense" hypocalcemia and do not secrete parathyroid hormone when required. Thus, calcitriol is not synthesized when needed. Calcium is not mobilized and the sensitive neuromuscular junction reacts in a convulsive or tetanic state. Administration of calcitriol and oral calcium is successfully used to correct this disorder.

VITAMIN D-RESISTANT RICKETS

A genetic defect known as vitamin D-dependency rickets type I (autosomal recessive) is in fact a defect in the renal conversion of calcidiol to calcitriol. This disorder is treated with physiologic amounts of calcitriol or pharmacological amounts of other vitamin D analogs. Still other genetically related bone diseases are known to include either primary or secondary disturbances in the vitamin D system.

OSTEOPOROSIS

An inability to increase intestinal absorption of calcium when required to meet organismal needs will result in calcium mobilization from bone to maintain blood calcium levels. This results in a chronic loss of bone. There is an age-dependent loss of calcium absorption and of bone mass which correlates with low blood levels of calcitriol. Post-menopausal osteoporotic women have blood calcitriol levels that also correlate with diminished calcium absorption. Administration of calcitriol to osteoporotic post-menopausal

women not only increases calcium absorption but also improves calcium balance, an effect that persists for up to two years. Thus, calcitriol appears promising as a therapeutic aid in preventing bone loss of old age and menopause. Definitive studies are now in progress.

SUMMARY

The relatively recent discovery of the vitamin D endocrine system has provided a new dimension in our understanding of metabolic bone diseases. In addition, these investigations

have provided new therapeutic tools for management of disorders of calcium and phosphorus metabolism. This area should continue to provide new approaches to the management of bone disorders.

REFERENCES

- Deluca HF: *Nutrition Reviews* 37:161-193, 1979.
Deluca HF: *Nutrition Reviews* 38:169-182, 1980.
Haussler MR and McCain TA: *N Engl J Med* 297:974-983 (Part I) and 1041-1050 (Part II), 1977.
Lawson DEM Editor: *Vitamin D*. Academic Press, London, 1978.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physicians Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

Trustees' Minutes May 19, 1981

The reorganization meeting of the Board of Trustees was held in Secaucus on May 19, 1981. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Introduction of New Members . . . Welcomed the following new members and newly elected officers: Bernard Robins, M.D., First District, Michael R. Ramundo, M.D., Second District, Harry W. Fullerton, Jr., M.D., Fifth District, Frank Y. Watson, M.D., Second Vice-President, Alexander D. Kovacs, M.D., First Vice-President, and Howard D. Slobodien, M.D., President-Elect.

Election of Chairman of the Board . . . Reelected William Greifinger, M.D., Chairman of the Board of Trustees, and agreed to continue meeting on the third Sunday of each month at the Executive Offices in Lawrenceville.

Introduction of MSNJ Auxiliary President . . . Announced the attendance of Mrs. Phyllis P. Romano, newly elected President of the MSNJ Auxiliary, who was officially recognized by the Board.

New Jersey State Medical Underwriters, Inc. . . . Received the 1981 annual report of the Medical Inter-Insurance Exchange of New Jersey and a shareholders' report from the New Jersey State Medical Underwriters, Inc. James S. Todd, M.D., chairman of the Board of Directors of New Jersey State Medical Underwriters, highlighted the following significant results of the four-year operation:

1. Twelve employees have been added, but expenses still run only six and a half percent of premium for the latest policy year.
2. The central office has relocated within the MSNJ facilities at Lawrenceville.
3. The Claims Department has been audited by the Hartford Insurance

Group and rated as "distinguished."

4. Investment results show excellent gains in the Exchange's limited equity holdings.

5. The data processing system has been developed to the point where it can be marketed to other insurance companies, receipts from which can be used to offset cost of the Underwriters' operations to the benefit of the membership.

. . . Ratified reappointment of Paul J. Kreutz, M.D., to a three-year term on the Board of Directors of the New Jersey State Medical Underwriters, Inc.

. . . Voted to approve a change in the Bylaws of the Underwriters to increase the number of members on the Board of Directors from seven to eight.

. . . Ratified the appointment of Mr. Peter Sweetland, President of Underwriters, to the newly created post—eighth member of the Board of Directors—for a term of three years.

. . . Noted that John S. Madara, M.D., has been designated as President Goracci's representative on the Board of Directors of the Underwriters.

Committee on Finance and Budget . . . Noted that Douglas M. Costabile, M.D., has been appointed by President Goracci to serve as Board of Trustees' member on the Standing Committee on Finance and Budget.

Reappointment of Salaried Personnel . . . Reappointed all salaried personnel at the terms agreed upon and at the salaries set forth in MSNJ's budget.

Investigation of Pharmacies . . . Agreed to postpone further consideration of co-operating in the investigation of pharmacies pending receipt of a report from Mr. Maressa on a meeting with the Deputy Attorney General to clarify particulars of the State Board of Medical Examiners' procedures in investigating retail pharmacies suspected of violating statutes regarding the dispensing of

drugs, for which the SBME has requested the names of physicians willing to provide prescriptions to be used in this investigatory procedure.

DRG Review Mechanism . . . Empowered the Executive Committee to pursue a meeting with the medical directors of PSROs in New Jersey to discuss the format of a peer review system under the DRG program.

Referrals from the 1981 House of Delegates

1. **Mandatory Membership in the AMA—Resolution #20 . . .** Adopted as amended by the House

RESOLVED, that the 1981 House of Delegates direct the Board of Trustees of the Medical Society of New Jersey to pursue every other means of increasing membership in the AMA through the activities of its regular committees.

. . . Agreed to implement the mandate of Resolution #20 by attendance of members of the Board of Trustees and the AMA Delegation at hospital staff quarterly meetings at each of the acute care hospitals in New Jersey. Dr. Baker was appointed to coordinate the program and develop an assignment schedule.

2. **Seating of Alternate Delegates—Resolution #13 . . .** Referred to the Board of Trustees for implementation

RESOLVED, that the Medical Society of New Jersey Bylaws be appropriately revised to allow greater participation by alternate delegates in the actions of the House of Delegates without penalizing the delegate for yielding his seat temporarily and thereby being denied seating for the remainder of the meeting.

. . . Referred Resolution #13 to the Committee on Annual Meeting and the Committee on Revision of Constitution and Bylaws.

3. **Comprehensive Legal Services Plan for Physicians—Resolution #23 . . .** Adopted as amended by Reference Committee "A"

RESOLVED, that the Medical Society of New Jersey consider providing a plan which offers comprehensive legal representation for physicians who are members of the Medical Society of New Jersey, through the conclusion of any complaint by the State Board of Medical Examiners.

... Directed that the intent of Resolution #23 be investigated by MSNJ staff in conjunction with the Committee on Medical Defense and Insurance.

4. Term of Service on State Board of Medical Examiners—Substitute Resolution #24 ... Adopted.

RESOLVED, that no member of the State Board of Medical Examiners serve more than two consecutive three-year terms, and, to preserve continuity, the terms of all members should be staggered.

... Referred Resolution #24 to the Council on Legislation

5. Equal Rights for Men and Women—Resolution #37 ... Adopted, as amended by the House.

RESOLVED, that the Medical Society of New Jersey urge the AMA to affirm the concept of equal rights for men and women.

... Referred Resolution #37 to the attention of the AMA Delegation.

6. AMA Department of Negotiations—Resolution #38E ... Adopted

RESOLVED, that the American Medical Association be encouraged to maintain the Department of Negotiations.

... Referred Resolution #38E to the attention of the AMA Delegation.

7. Discontinuance of Funding of the New Jersey Foundation for Health Care Evaluation—Resolution #33 ... Adopted

RESOLVED, that the New Jersey Foundation for Health Care Evaluation no longer be funded by the Medical Society for New Jersey, and that any services necessary to the Society's membership be provided by the Board of Trustees or their appointees.

... Resolution #33 was noted and filed.

Note: The present commitment to the Foundation extends to December 31, 1981, therefore requests for the continuance of functions performed by the Foundation can be addressed by the Board until the end of the year.

8. Payment of MSNJ Dues on the Installment Plan—Resolution #19 ... Re-

ferred to Board of Trustees

RESOLVED, that the 1981 House of Delegates direct the Board of Trustees of the Medical Society of New Jersey to provide immediately the necessary alternative mechanisms and arrangements for the payment of the 1982 MSNJ dues—and for all subsequent years—either by quarterly installments or by monthly installments, for those physicians who really want to retain their memberships in the Medical Society of New Jersey and in their county medical societies, but whose financial circumstances make this form of deferred payment a necessity.

Referred Resolution #19 to the Committee on Finance and Budget for implementation.

9. New Dues-Paying Methodology for State and AMA Dues—Resolution #34 ... Referred to Board of Trustees

RESOLVED, that the Medical Society of New Jersey, and also the American Medical Association, actively look into and implement a system for deferred computerized billings as a mechanism for increasing the membership of practicing physicians in the rank of organized medicine at this time when this is so needed, and that the New Jersey delegates to the AMA actively push for the study and quick implementation of such a billing method.

... Referred Resolution #34 to the Committee on Finance and Budget for implementation

10. Blue Cross Coverage for Rehabilitation Treatment—Resolution #3 ... Referred to the Board of Trustees by the House for the identification of problems and for the determination of the need for this resolution.

RESOLVED, that the Medical Society of New Jersey advocate and support necessary changes in Blue Cross contracts to make possible adequate coverage for the necessary completion of rehabilitation treatment of patients requiring such services; and be it further

RESOLVED, that the present, unrealistic \$50 a year limit for rehabilitation treatment be changed so that rehabilitation treatment may be received on an outpatient basis whenever feasible and indicated, thereby avoiding expensive and extended hospitalizations.

... Referred Resolution #3 to the Council on Medical Services for study and report.

11. Dual Fee System—Resolution #30 ... Referred to the Board of Trustees by the House to study the Michigan experience over a period of time and the consequences thereof.

RESOLVED, that the Medical Society of New Jersey take all action necessary to prevent fee discrimination by third party carrier, and to assure that physicians are compensated for the service rendered rather than by specialty designation.

... Referred Resolution #30 to the Council on Medical Services for study and report.

12. Opposition to Health Systems Agencies—Resolution #9 ... Adopted

RESOLVED, that the Medical Society of New Jersey go on record as being opposed to the continuing authority of these consumer-dominated health systems agencies to mandate the degree and direction of future health care; and be it further

RESOLVED, that the Medical Society of New Jersey make known to the public its opinion, as an organization of health care providers, that there is little justification for the continued cost to the taxpayers of these politically motivated agencies.

Directed that Resolution #9 be referred to the attention of the AMA Delegation and the Council on Public Relations.

13. Health Systems Agencies (HSAs)—Resolution #25 ... Adopted, as amended by Reference Committee "F"

RESOLVED, that the Medical Society of New Jersey memorialize the AMA to continue to seek repeal of P.L. 93-641 (National Health Planning and Resources Development Act); and be it further

RESOLVED, that the Medical Society of New Jersey develop a means to promote the involvement of member physicians in health planning.

... Directed that Resolution #25 be referred to the attention of the AMA Delegation and the Council on Public Relations.

14. Discontinuance of Funding for Health Maintenance Organizations—Resolution #16 ... Adopted

RESOLVED, that the Medical Society of New Jersey urge the House of Delegates of the American Medical Association to recommend to the enabling committees of Congress and to the Health Care Finance Administration (HCFA) that any further grants or loans to health maintenance organizations be abolished.

... Directed that Resolution #16 be referred to the attention of the AMA Delegation.

15. Five-Digit Procedure Coding—Reso-

lution #18 . . . Both the resolution and proposed amendment (italics) were referred by the House to the Board of Trustees.

RESOLVED, that the Medical Society of New Jersey be recorded as favoring five-digit procedure coding; and be it further

RESOLVED, that the Medical Society of New Jersey notify the major health insurance carriers in New Jersey, and request them to adopt *an appropriate, nationally used five-digit procedure coding system, such as the CPT-4 or the ICD-9-CM coding system.*

. . . Referred to the Council on Medical Services for study and report and noted the importance of establishing dialogue with the New Jersey Hospital Association and other groups.

Reference Committee "H" . . . Referred to the administrative staff of MSNJ for implementation a recommendation from Reference Committee "H" that its functions be expanded to include referrals of certain other committee reports so as to carry a fuller share of the responsibilities of all reference committees, such as the Committee on Medicine and Religion, Committee on Impaired Physicians and Committee on Publication.

JEMPAC Board of Directors . . . Approved the list of individuals from which appointments will be made to the Board of Directors of JEMPAC.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

Each month, I enjoy sharing with you the steady progress of CMDNJ's programs in health sciences education, community health ventures and research in the basic and clinical sciences. This month, however, I'd like to direct your attention to a more sobering topic—current government fiscal policy, and its impact on CMDNJ and health sciences institutions nationwide.

As you know, there is a growing trend by government, at both the state and the federal level, to cut back on its support to health care and to health professions education. Although the specific losses are not yet completely clear, it is evident that CMDNJ and other institutions providing health services and health sci-

ences education will be affected greatly by these reductions in funding.

Our current projections show an expected deficit of nearly \$8 million in CMDNJ's State appropriation for the current fiscal year. Hardest hit by the shortfall will be CMDNJ-College Hospital, for which the State's appropriation falls nearly \$5 million short of its needs. This figure includes a \$3.2 million over-estimate of the hospital's income based on our experience last year, during which occupancy rates were lower and indigency rates higher than the State budget allowed for. Another \$1.2 million is needed by the hospital to offer competitive salaries to nurses, and \$.5 million for family planning and emergency service programs, which no longer can be funded by Federal grants.

The hospital's projected deficit does not allow for additional losses which are expected to result from proposed Federal budget cutbacks. Funding is in jeopardy for a number of health services programs needed by the Newark community, and these may have to be absorbed into the hospital's budget or dropped. In addition, Medicare, Medicaid and other programs which assist the needy with health care costs are slated for large reductions and this will increase the number of medically indigent patients seeking care at the hospital.

Obviously, this combination of financial problems will necessitate a reexamination of College Hospital's priorities. The faculty is unique in that it has been charged by the State with a dual mission, as a tertiary care resource for the entire State and primary teaching facility to the educational units, and as a primary care hospital serving the Newark community. As funds get tighter, the hospital may be forced to make decisions about closing programs.

The College's educational programs also are affected by reductions in public support. Our six schools must cover, from their already austere budgets, a deficit in State funding of nearly \$3 million caused by skyrocketing fuel and utilities costs. Federal cutbacks include capitation grants, the direct subsidy to schools of medicine and dentistry, which are slated to be eliminated completely, costing CMDNJ a total of \$450,000. Training grants, which help support educational programs and residencies at each of the schools, are expected to be cut severely, and CMDNJ currently has more than \$2 million in current or pending grants of this type.

Research monies also will be tighter under the proposed Federal budget,

since funding for the National Institutes of Health is proposed at ten percent below the amount needed to maintain last year's level of activity. Competition for new grants will be more severe, and grants awarded no longer will fund equipment purchases or institutional overhead, thus increasing the financial burden on the recipient institution. Since more than 70 percent of CMDNJ's \$10 million in research support comes from the NIH, the impact of these cutbacks on the College is expected to be serious.

Another area of concern is our students. Over the years, escalating costs have driven our tuition rates to the point where we are the second most expensive public health sciences institution in the country. At one of our medical schools, the collective debt at graduation topped \$2 million with an average of \$27,000 per student, with a few owing in excess of \$45,000. But this is just the beginning.

While costs to educate students continue to rise, student assistance funds are becoming scarcer. Reductions in the Federal Guaranteed Student Loan program, an interest-subsidized program in which 75 to 80 percent of our students participate, are expected to result in a decrease of 50 percent in the funds available to New Jerseyans. Another major resource, the National Health Service Corps scholarship program, which currently provides full tuition and stipend support for 124 CMDNJ students, is slated to be phased out entirely. In order to finance a medical education, more and more students are being forced to obtain loans on the open market at double-digit interest rates.

Ultimately, we must ask ourselves, who is going to be able to attend our health professions' schools. Will the poor, and even the middle class, student be driven out of the applicant pool because the costs are just too high?

Again, CMDNJ will be forced to take a hard look at its priorities. The College was founded specifically so that New Jersey's most promising young people would have the opportunity to pursue careers in the health sciences, and so that the State could be provided with an adequate supply of professionals who are interested and willing to serve New Jersey's health care needs. Over the past decade, we have succeeded in encouraging increasing numbers of our graduates to set up practice in the State's medically neediest areas.

Now, as students are faced with amassing larger and larger educational debts, the College's mission may be defeated. New Jersey's best students may

seek education at out-of-state institutions, which, by virtue of their long establishment, can offer them better student assistance resources. Others will be forced to choose their residencies and practices on the basis of financial considerations rather than their interests and the State's needs.

These problems are by no means unique to CMDNJ or to New Jersey. They are matters of national concern, for which there are no easy solutions. I present them to you for your consideration, because all of us who are involved in health care and health professions education must be prepared to adjust our priorities and alter our outlook in the years ahead.

DESAD Project

The recently completed, five-institution study of diethylstilbestrol (DES) exposure *in utero*, supported by the National Cancer Institute, has elicited recommendations from the research investigators of the project who are practicing physicians at the Mayo Clinic, Massachusetts General Hospital, Baylor College of Medicine, the University of Southern California, and the Gundersen Clinic. These are available in pamphlet form and include colored illustrations of frequently detected abnormalities and pathological specimens. The pamphlet, entitled "Information for Physicians" (DESAD Project), NIH Publication No. 81-2049, is available without charge from the National Cancer Institute, National Institutes of Health, Bethesda, Maryland 20205.

Two other up-to-date publications on this subject also are available, free of charge, "Questions and Answers About DES Exposure During Pregnancy and Before Birth,"—NIH No. 80-1118, and "Were You or Your Daughter or Son Born After 1940?"—NIH No. 81-1226, both of which contain information for patients when DES exposure is confirmed.

Soon to be published is an atlas on this subject which contains information for physicians with many more illustrations. Each of these is available from the National Cancer Institute.

216th Annual Meeting

Medical Society of New Jersey

Resorts International Atlantic City

May 14-17, 1982

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY—Parvin Javadi, M.D., P.O. Box 50, Bradford, PA 16701. Pahlavi Medical School (Iran) 1964. Board eligible. Group, partnership, solo, academic. Available.

CARDIOLOGY—Lawrence J. Gessman, M.D., 21 Sabine Avenue, Narberth, PA 19072. University of Pennsylvania 1974. Board certified. Group, partnership (preferably with cardiac catheterization). Available.

G. R. Kolluru, M.D., 914 South Avenue, Apt. E-33, Secane, PA 19018. Andhra (India) 1973. Board certified (IM). Group, partnership, solo. Available.

FAMILY MEDICINE—Allan P. Oliveri, M.D., 120 West 80th Street, New York, NY 10024. Cornell 1976. Board certified. Group, partnership, hospital affiliate (full time). Available.

Louis Verardo, M.D., 21 Walnut Road, Apt. 1—2A, Glen Cove, NY 11542. University of Bologna (Italy) 1978. Board eligible. Group (private or hospital-sponsored), preferably with opportunities for medical school/residency affiliation (for teaching purposes). Available August 1981. K. J. Smith, M.D., P.O. Box 486, Durham, PA 18039. University of Washington 1976. Board eligible. Group. Available.

INTERNAL MEDICINE—Prabhakar N. Vaidya, M.D., 7752 Montgomery Road, Apt. 81, Cincinnati, OH 45236. Seth G.S. Medical College (India) 1969. Board certified. Single or multi-specialty group, partnership, or hospital-based. Available. Lakhu Janimal Rohra, M.D., 86-19 Elmhurst Avenue, Apt. 3-E, Elmhurst, New York 11373. Baroda (India). Board eligible. Solo, associate, group. Available. M. A. Menon, M.D., 355 Crale Boulevard, #202, Melvindale, MI 48122. Armed Forces Medical College (India) 1974. Sub-specialty, gastroenterology. Board certified. Group, solo. Available. Bankim D. Shah, M.D., 100 Hospital Plaza, #705, Paterson, NJ 07503. T.N. Medical (India) 1974. Group, partnership, solo. Available.

Rakesh Anand, M.D., 412 Maryland Avenue, Apt. 3-C, Staten Island, NY 10305. Medical Institute, New Delhi (India) 1973. Board certified. Solo, partnership, group. Available on one to two months' notice.

Marzie T. Nejad, M.D., 2200 Benjamin Franklin Parkway, Apt. S-1105, Philadelphia, PA 19130. Tehran University (Iran) 1969. Subspecialty, nephrology. Board eligible. Hospital-based, partnership, group. Available.

Kamal M. Bakri, M.D., 88 Slate Creek Drive, Apt. #3, Cheektowaga, NY 14227. Baroda (India) 1973. Subspecialty, oncology. Board certified. Group, solo, or partnership. Available.

Peter E. Schottlander, M.D., 2408 Whittier Street, Rahway, NJ 07065. CMDNJ 1979. Board eligible. Partnership or group. Available July 1982.

Ruth C. Wang-Liang, M.D., 68 Colfax Road, Wayne, NJ 07470. Temple 1978. Board eligible. Group, HMO. Available.

NUCLEAR MEDICINE—M. I. Straub, M.D., 254 Frances Street, Teaneck, NJ 07666. Semmelweis (Hungary). Special interest, diagnostic radiology. Board eligible. Available.

OBSTETRICS/GYNECOLOGY—F. Adibi, M.D., 84 Skyline Drive, Chalfont, PA 18914. Tehran (Iran) 1967. Board certified. Group/partnership. Available.

Dilipkumar G. Patel, M.D., 72 Duke Street, New Brunswick, NJ 08901. Baroda (India) 1974. Board eligible. Group, associate, solo, hospital. Available.

Mohammed M. Mohiuddin, M.D., 215 Locksley Road, Syracuse, NY 13224. Osmania (India) 1973. Board eligible. Any type practice except academic position. Available.

Mridu B. Agarwal, M.D., 318 East 15th Street, Apt. 6-A, New York, NY 10003. Lady Hardinge (India) 1971. Solo, group.

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREbro-NICIN® capsule
contains:

Pentylenetetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



or partnership. Available.

Jung Fu Chen, M.D., P.O. Box 218, Petersburg, WV 26847. National Taiwan University 1956. Board eligible. Partnership, solo. Available.

OTOLARYNGOLOGY—Donald V. Wilson, M.D., 20 Lahiki Circle, Aiea, Hawaii 96701. Temple 1975. Board certified. Group, partnership, will consider solo. Available August 1982.

PATHOLOGY—Alexander J. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified (AP and CP). Any type practice including institutional. Available.

Aruna Kumar, M.D., 6223-B Newport Avenue, Norfolk, VA 23505. J.L.N. Medical (India) 1972. Board eligible (AP/CP). Group, solo, or partnership. Available.

PEDIATRICS—Fe C. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified. Any type practice. Available.

Yogesh J. Pandya, M.D., 24 Paerdeg—15th Street, Brooklyn, NY 11236. Baroda (India) 1973. Board eligible. Solo, group, partnership, hospital-based. Available.

Susheela Raghunathan, M.D., 9 Weston Place, East Brunswick, NJ 08816. India 1973. Board eligible. Group, institutional, clinic, emergency room, or house staff, student health center. Available.

PHYSIATRY—Lata Bhansali, M.D., 49 Hamilton Lane South, Plainsboro, NJ 08536. LTM Medical College (India) 1972. Board eligible. Group, clinic, or as staff. Available.

PSYCHIATRY—Paul L. Maitheny, M.D., 99 Pawnee Road, Lakewood, NJ 08701. University of Graz (Austria) 1951. Board eligible. Available September 1981.

PULMONARY DISEASES—Paul M. Friedman, M.D., 1303 York Avenue, New York, NY 10021. SUNY-Downstate 1977. Board certified (IM). Group or partnership. Available July 1982.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379. Shah (India) 1969. General practice and rehabilitation medicine. Available on three months' notice.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available.

Thomas A. Giangrasso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available.

SURGERY, GENERAL—S. R. Bajina, M.D., E1501, Park Towne Place, 2200 Benjamin Franklin Parkway, Philadelphia, PA 19130. Special interest—gastrointestinal endoscopy. Board certified. Solo, group, institutional-based. Available.

Rajendra M. Agarwal, M.D., 318 East 15th

Street, New York, NY 10003. King George's (India) 1968. Solo, group, or partnership. Available.

P. Joshua Mammen, M.D., 404 West 51st Street, Apt. 2-B, New York, NY 10019. Trivandrum (India) 1970. Board eligible. Group, partnership, solo. Available.

B. Paulauskas, M.D., Route 1, Box 273-M, Lake Placid, FL 33852. Lithuania 1972. Special interest, vascular surgery. Board eligible. Group, partnership, solo. Available.

Kong Hua L. Go, M.D., 605 Louisiana Avenue, Apt. 17-A, Brooklyn, NY 11239. Far Eastern (Philippines) 1973. Board eligible. Any type practice. Available.

Job S. Kakkasseril, M.D., 3194 McGill Lane, Cincinnati, OH 45239. Pradesh (India) 1972. Board eligible. Group, solo, or partnership. Available.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available.

Inder J. Singh, M.D., WCMC #1-C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available.

UROLOGY—Talluri Balaji, M.D., 1926 West Harrison St., Apt. 916, Chicago, IL 60612. Osmania (India) 1973. Solo. Available July 1982.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available.

Robert D. Zimmerman, M.D., 206 Friar Lane, Clifton, NJ 07013. Chicago Rush-Presbyterian. Board eligible. Partnership, solo, group. Available.

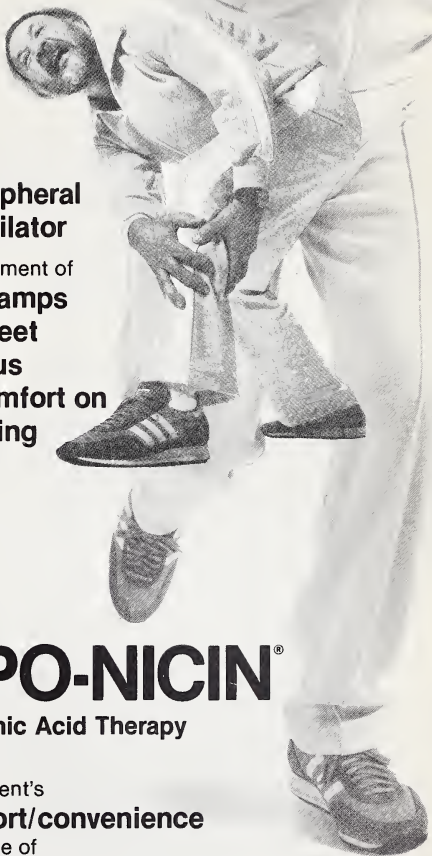
Mahendra S. Shah, M.D., 62 Forsythia Lane, Paramus, NJ 07652. Baroda (India) 1968. Board certified. Group or partnership. Available.

Tahmoures Furooz, M.D., 3646 Tuscula Avenue, Seaford, NY 11783. Esfahan University (Iran) 1966. Board eligible. Any type practice. Available.

Albert E. Kaufman, M.D., 2020 Forestdale Drive, Silver Spring, MD 20903. Ghent (Belgium) 1974. Board certified. Group, partnership. Available October 1981.

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing



LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid300 mg.
Ascorbic Acid150 mg.
Thiamine HCL (B-1)25 mg.
Riboflavin (B-2)2 mg.
Pyridoxine HCL (B-6)10 mg.

in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid250 mg.
Niacinamide75 mg.
Ascorbic Acid150 mg.
Thiamine HCL (B-1)25 mg.
Riboflavin (B-2)2 mg.
Pyridoxine HCL (B-6)10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid100 mg.
Niacinamide75 mg.
Ascorbic Acid150 mg.
Thiamine HCL (B-1)25 mg.
Riboflavin (B-2)2 mg.
Pyridoxine HCL (B-6)10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Removal of Pacemakers

May 30, 1981

Dear Editor:

In reference to the article, "Removal of Unnecessary Pacemakers" (*J Med Soc NJ* 77:877-881, (Dec) 1980), the major problem is not in determining whether a complete pacemaker system should be explanted but in placing the complete pacemaker system with acceptable and current indications. Three of the four cases cited give no specific indication for pacing. In case #4 why was a complete pacemaker system inserted for complete heart block in the presence of an acute inferior wall myocardial infarction? This is often transitory and at best usually only requires a transvenous pacemaker.

In terms of cost/effectiveness it seems unreasonable when a patient receives a pacemaker for supposedly valid indications to subject the patient then to the cost, extensive retesting, rehospitalization and repeat risk of surgery for explantation of that pacemaker. Are we to suppose that the cardiac disease improved and that the patient no longer needs a pacemaker on the basis of a normal holter monitor, graded exercise stress test or transtelephonic monitoring which only represents a small spectrum of time?

It is very hard to accept the method of pacemaker weaning by battery depletion and waiting for symptoms to occur in a patient. The only way that this could be done with some safety is for the patient to be hospitalized so that the pacemaker battery could be replaced or recharged immediately in the event of dramatic symptoms such as syncope. Hospitalization as in case #3 for eight weeks would be of tremendous cost to the patient and add to the inflationary problems of medicine in general.

It also seems ridiculous to subject a patient to a pacemaker change to a programmable unit just to determine whether the patient is pacer dependent, as is suggested in table #2. This again adds to the sky-rocketing cost of medi-

cine, since pacemakers at the present are not reusable and subjects the patient to another surgical procedure with its attendant risks.

The fact that the patient is not pacer dependent as is determined by reprogramming down the pacemaker rate, external overdrive or sinus rate greater than the pacemaker rate on repeated holter monitor or transtelephonic monitor strips does not mean that the patient does not require a pacemaker and that the pacemaker can be explanted.

In determining whether a pacemaker should be explanted, which tests should be selected: holter, graded exercise stress test or transtelephonic monitoring; if not all of them? How many times should they be repeated and be normal before it is indicated to remove the patient's pacemaker? The answers to these questions I do not think are known.

Costs would be exorbitant to determine whether a pacemaker should be explanted: holter monitoring for 72 hours would cost \$450-\$540; transtelephonic monitoring 3x/week at \$75/week; graded exercise stress test at \$110-\$120; pulse generator replacement with programmable pacemaker at \$1800-\$2900, and daily hospital costs, surgical operating room and physician charges. The costs and risks involved are not worth finding the few needlessly inserted pacemakers in the first place.

In summary, pacemakers probably should not be checked for possible explantation because of the high costs, added risks and few yields, but should be inserted with acceptable and current indications.

(signed) Russell J. Cornell, M.D.
Glenn Jacobs, M.D.

June 29, 1981

Dear Editor:

We are delighted that our report on the "Removal of Unnecessary Pacemakers" has stimulated discussion by letters to the editor. The point of the article was to have cardiologists and

internists in New Jersey examine patients who had pacemakers more closely, at the time the pacemakers came due for replacement. Such close examination can in some instances result in the immediate or the eventual removal of the pacemaker completely from the patient. The cost of a new pacemaker now is as high as \$3,750 and there are other costs such as hospitalization, and followup by telephone or in the doctor's office.

It should be understood that we do not advocate hospitalization for examination of patients who have normally functioning pacemakers to see if the pacemakers are necessary. What we are suggesting should be carried on in the back of the doctor's mind during the time he is following the patient and reading reports of tests which were scheduled for other reasons. These include telephone monitoring of the pacemaker rate, and in some cases, holter monitoring because of tachycardias.

We agree that it is unacceptable to test pacemaker need by allowing total battery depletion in the usual case; that is why we advocate programmable pacemakers which can be set at a very low rate to see if the patient really does need a pacemaker when this is the question thus giving the patient the safety backup rate.

We note that putting a programmable unit in a patient now is the routine in an increasing number of centers (and is not "uncalled for"). We are advocating a programmable unit as a replacement pacemaker in these cases. This would happen anyway in many cases in the practice of physicians who do not even think of the question of whether the patient really needs a pacemaker. Putting in a programmable unit if the patient really does need the pacemaker may save his life. On the other hand if he really does not need the pacemaker it may show that to be true and does not seem "ridiculous".

In the last paragraph it is stated that pacemakers probably should not be checked for possible explantation be-

cause of the high cost. The whole idea of the explantation of the pacemaker is that in a few patients the whole cost of the new pacemaker and of the hospitalization and of the further followup may be avoided by these tests. With the pacemaker cost at more than \$3,000 and hospitalization at more than \$1,000 not to speak of the doctor's fee or the cost of further followup, it seems that the cost of the recommended tests is worth while in suspected cases.

(signed) Dryden Morse, M.D.
Al Gooch, M.D.

P.S. We would like to invite the authors of the letter criticizing our article and others interested to come visit our hospital and discuss these problems with us. We all can use the guidance and advice of our colleagues.

Physicians and Gun Control

June 19, 1981

Dear Dr. Krosnick,

Your editorial on physicians and gun control was quite interesting, particularly in your references (interchangeable) to murder and assassination as the American Disease. This phrase arose in Europe over the past decade as an ethnic slur pertaining to assassinations and attempted assassinations which occurred in our country at a higher rate than on the continent. Given our political system, where lack of true issues necessitates a ridiculous amount of public exposure, a higher incidence must be expected here. Please note, however, that British and Vatican strains are not unknown. For some reason the American press has chosen not only to accept this slur but to enhance it by applying it to all firearms-related crimes. I was somewhat disheartened to see you follow their lead rather than fully research the terminology.

You also chose to accept their statistics as they most often are presented in the press. When one reads of a hit-and-run driver, statistics concerning the number of cars on the road and how many are imported rarely are stated. The heritage of this country has always included the ownership of firearms. On a per capita basis the ratio of firearms' owners to population has probably decreased with large collector inventories, creating the numbers you stated. In fact less than five percent of the firearms in this country are ever involved in crimes.

Your call for far-reaching controls of all guns ideally to effect the usage of this small percent seems out of line with your own analogy to treating "our" disease. I would tend to liken it to compulsory mastectomies to limit breast cancer.

You do state that U.S. gun regulations abound in number. Their ineffectiveness, at any level, is also a known fact. Recent years have seen a particular increase in crimes in areas boasting "strict" controls. Polls conducted in the after shock of an assassination attempt are bound to be unreliable. Any poll can be skewed by the choice of questions just as a medical interview can. In any public referendum (including our own recent Democratic primary) the public has turned down gun control. More than enough restrictions now exist. They serve only as poultices and incantations to the problem. The causative agent is evident and must be the target of your efforts.

Judicial enforcement of existing laws is as abysmal as surgical sterility before Lister. Most violent crime is credited to repeat offenders. Liberal courts no longer seek to protect the public as evidenced by the recent New York judge who threw out a conviction against the confessed murderers of a Bronx teenager because their attorney had allowed them to plead guilty without plea bargaining to a charge which would have them on the street sooner. If we are to treat a disease we must be able to use what medical science has taught us. Isolate the infected with effective quarantine until a cure can be honestly documented. Keep "carriers" out of society. Don't oppose justifiable amputation of a diseased part. Demand respect for the disease from those in a position to act upon it, judges and attorneys.

Review the recent judicial actions concerning Abbie Hoffman and Jean Harris. Try to find out what action was taken in other headline stories of violent crime you recently may have read. Medication is at hand but its administration channel is defective.

More controls? These can be likened to CNs and DRGs as a control on medical costs. How would you consider these if overspending was only present in five percent of cases? Legal professionals have been quick to scrutinize medicine's request for CAT scanners and the like and to demand more perfect standard of care for the public good. Its time for the medical profession to turn the tables and place such demands on the judicial system.

(signed) Robert J. Baran, M.D.

Suburban Consultant: A Personal Philosophy

June 30, 1981

Dear Editor:

The role of physician consultant in a suburban community is unique. It involves a very active schedule with severely ill people, contacts with well-trained colleagues and the use of sophisticated services. The physician is expected to practice on a scientific level equal to the academic but be as kindly, devoted and painstaking as the Family Physician of previous generations is said to have been.

There are enormous demands for time and for attention to activities not directly related to patient care. The obligation for hospital and community service and the restrictive requirements of regulated professional life reduce time available and increase pressures of daily function.

Financial independence would be ideal and allow service where most needed. Very few physicians have this independence. Time must be apportioned according to the importance of demands. It becomes necessary to arrange one's life and accept each day's challenges. In this way, seeing the contribution to health and comfort becomes in itself a reward.

The physician is a lifetime and solitary student. Should he serve in a suburban setting, he does not have time for daily contact with centers of knowledge. Therefore he becomes more independent in thought. He must study everything he can—journals, magazines, newspapers, mailings, what his colleagues talk about and even sometimes the television. The rapid increase in the amount of information causes him to narrow the area of his interest but he must never stop studying.

A small community exudes the aroma of its residents. The jangling of events and the dangling of people produce a distinctive flavor. The people in a community must be studied too! There are differences between communities—ethnic, ethic, moral, social, cultural, occupational and economic—that impinge on health care behavior.

In some instances, it is an advantage to know personal things about people—to understand them and their problems better. In this fashion, better compliance with treatment advice may produce a result more favorable to the patient.

In a small community, referrals are received from colleagues, friends and patients. Referrals from patients are the most gratifying. A consultation should mean communication between the atten-

ding physician and his consultant. There should be an understanding of their respective roles. After the consultation, the patient is entitled to know that they are in agreement or to know each opinion if they are not in agreement.

The public has peculiar and distorted notions about physicians, gained by extensive but uncritical observations of characters in print and on the tube. Some people try, perhaps unwittingly, to push a consultant into taking sides between members of a family, between patients and family and even between family and attending physician. The

consultant must be wary, not paranoid but wary. In the suburbs, where people have a likelihood of knowing each other, familiarity may be used as a tool to achieve a predetermined result—not always beneficial to the patient.

It is difficult for consultants to keep in touch with patients but in this kind of community unusual sources of information help. Informal contacts—the cocktail party, the hairdresser or the gasoline station often deliver the news. Just listening is sometimes helpful.

When a consultation is completed, the referring physician is entitled to a writ-

ten report. This should be prepared promptly and should contain three items: (1) a summary of the patient's status, (2) a summary of the consultant's diagnoses, (3) recommendations for future management.

The most annoying consultant is the one who sees the patient and prescribes for the patient without communicating with the attending physician.

A little extra effort in learning the attending physician's needs and helping to care for the patient will make everyone happier and is more likely to be effective.

(signed) Albert Abraham, M.D.

PERSONAL ITEMS

Dr. Saffron Elected Honorary Fellow

Morris H. Saffron, M.D. was elected an Honorary Fellow of the Academy of Medicine at the March meeting of the Board of Trustees of that body and the presentation of this special award was made at the Academy's Annual Awards Dinner on May 27. Dr. Saffron, who was president of AMNJ in 1965-1966, has served as archivist/historian, curator of the museum and editor of AMNJ Bulletin, and just has completed writing the Academy's 70-year history.

He is a past-president of the New Jersey Academy of Science and the New Jersey Dermatological Society and currently is a Trustee of the New Jersey Historical Society. He is chairman of the Friends of the Libraries of Columbia University and among his many honors is the Presidential Citation for Excellence from Columbia University.

Dr. Saffron was the principal mover in the founding of the Medical History Society of New Jersey and currently serves that organization as counsellor. He is visiting professor of medicine (medical history), New Jersey Medical School, CMDNJ and is curator of the Museum Collection at Rutgers Medical School. He is the author of a number of books, the most recent of which is *Surgeon to Washington: Dr. John Cochran (1730-1807)*, published by Columbia University Press.

Dr. Iskowitz President of Physical Medicine Society

Robert Iskowitz, M.D., the Medical Director of the Department of Rehabilitation Medicine at Helene Fuld Medical Center in Trenton, was elected President of the New Jersey Society of Physical Medicine and Rehabilitation at the Society's meeting in May. Dr. Iskowitz is a graduate of Downstate Medical Center—SUNY where he also took a three-year residency in rehabilitation medicine. He has taught that specialty at Georgetown University Medical School, Temple University Medical School and the Hahnemann Medical College. He is a Fellow of the American Academy of Physical Medicine and Rehabilitation and a member of the American Congress of Rehabilitation Medicine and the American Association of Electromyography and Electrodiagnosis.

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Sept.

- 8 **New Developments in Analgesia**
7-8 p.m.—Saddle Brook General Hospital
(Saddle Brook General Hospital and AMNJ)
- 26 **Total Nutritional Replacement**
- 27 8 a.m.-5 p.m.—Resorts International Hotel, Atlantic City
(CDMNJ-NJ Medical School and AMNJ)

CARDIOLOGY

Sept.

- 23 **Heart Disease in the Elderly**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

Oct.

- 1 **Coronary Artery Disease**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)
- 14 **Mitral Valve Prolapse**
2 p.m.—John E. Rannels Hospital, Berkeley Heights
(AMNJ)
- 28 **Nuclear Cardiology**
1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Sept.

- 2 **Dinner Meeting—Endocrinology Section, AMNJ**
6-9:30 p.m.—Holiday Inn, East Orange
(AMNJ)
- 2 **Endocrine Conference**
- 9 3:30-5 p.m.—Rotates between Newark
- 16 Beth Israel Medical Center, College
- 23 Hospital, Newark and VA Medical
- 30 Center, East Orange
(AMNJ)
- 2 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(AMNJ)
- 3 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical

Center

- (AMNJ)*
- 3 **Adolescent Drug Addiction**
9 a.m.—Freehold Area Hospital
(AMNJ)
- 4 **Thrombolytic Therapy in Pulmonary Embolism**
- 15 **Dissecting Aneurysm of the Aorta**
12 noon—St. Mary's Hospital, Orange
(AMNJ)
- 4 **Medical Grand Rounds**
11:30 a.m.—College Hospital, Newark
(AMNJ)
- 9 **Clinical Immunology**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)
- 14 **Liver Trauma**
7:45-9 a.m.—Newark Beth Israel Medical Center
(Newark Beth Israel Medical Center and AMNJ)
- 16 **Sarcoidosis**
- 23 **Heart Disease in the Elderly**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)
- 16 **Rheumatology and Infectious Disease**
9 a.m.-12 noon—Overlook Hospital, Summit
(NJ Academy of Family Physicians, Overlook Hospital and AMNJ)
- 16 **Hospital Malnutrition**
- 23 **Pelvic Inflammatory Disease**
1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)
- 18 **Emergency Care/Diagnosis and Treatment of Shock**
12 noon—Freehold Area Hospital
(AMNJ)
- 21 **Interpretative Problems in Upper GI Tract Disease**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)
- 21 **Anaerobic Infections**
7-8 p.m.—Paul Kimball Hospital, Lakewood
(Paul Kimball Hospital and AMNJ)
- 22 **Treatment of A.L.L.**
7-9 p.m.—Coachman Inn, 10 Jackson Dr., Cranford
(New Jersey Blood Club and AMNJ)
- 22 **Dermatology**
8 p.m.—Warren Hospital, Phillipsburg
(AMNJ)
- 30 **Corticosteroid Therapy**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)
- 30 **Martin Gold Memorial Seminar—Genetic Control**
1:30-5 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

Oct.

- 1 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(AMNJ)
- 1 **Symposium for Emergency Physicians**
9 a.m.-5:30 p.m.
- 2 8:30 a.m.-4 p.m.—Bally's Park Place, Atlantic City
(New Jersey ACEP and AMNJ)
- 2 **Medical Grand Rounds**
11:30 a.m.—College Hospital, Newark
(AMNJ)
- 2 **Prophylactic Antibiotics**
12 noon—Freehold Area Hospital
(AMNJ)
- 2 **Hypertension**
12 noon—St. Mary's Hospital, Orange
(AMNJ)
- Second Annual Consecutive Case Conference**
- 2 9 a.m.-2:30 p.m.
- 4 9 a.m.-12 noon—Playboy Resort, Great George, McAfee
(New Jersey Thoracic Society and AMNJ)
- 6 **Hematology**
11 a.m.—Greystone Park Psychiatric Hospital
(AMNJ)
- 7 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(AMNJ)
- 7 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(Endocrinology Section of AMNJ)
- 7 **Antimicrobial Therapy in Childhood**
- 14 **Differential Diagnosis of Acute Arthritis**
- 21 **Current Problems in Occupational Medicine of Interest to Primary Care Physicians**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)
- 7 **Urethral Syndrome**
- 14 **Non-Cardiac Pulmonary Edema**
- 21 **To be announced**
- 28 **Prostaglandins**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)
- 7 **Endocrine Conferences**
- 14 3:30-5 p.m.—Rotates between Newark
- 21 Beth Israel Medical Center, College
- 28 Hospital, Newark and VA Medical Center, East Orange
(Endocrinology Section of AMNJ)
- 9 **Symposium on Health and Obesity**
8 a.m.-5 p.m.—Rutgers Medical School, Piscataway
(CMDNJ)

**American College of Emergency Physicians
New Jersey Chapter**

Annual Symposium

"A Sure Bet: Emergency Services 1981"

October 1 & 2, 1981

Bally's Park Place Casino and Hotel
Atlantic City, N.J.

Physician fee: \$160 ACEP Members
\$200 Non-Members

For more information contact:

Linda Bartolo
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, N.J. 08648 609-896-1717

**SNOWMASS/VAIL "MEP" SKI SEMINAR ON
MANAGEMENT ENRICHMENT FOR THE
HEALTH PROFESSIONAL**

Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or ski Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Trip expenses deductible for doctor and spouse. For information: MEP, An Education Corporation, 906 Cooper Avenue, Glenwood Springs, Colorado 81601; or 1-800-525-3402.

**TUITION ASSISTANCE
PROGRAM, INC.**

Matching communities-seeking-physicians with physicians-in-training requiring tuition assistance. Write for more information.

Keith Hummel, Director
Tuition Assistance Program Inc.
Box 6221
Duluth, MN 55806

June Open Enrollment!!! Doctors: There's still time to sign up for group major medical!

**BROAD COVERAGE FOR MEMBERS
PARTICIPATING IN BASIC
GROUP BLUECROSS/BLUESHIELD PROGRAMS**

Officially Endorsed by the Medical Society of New Jersey

For More Information Contact:

DONALD F. SMITH & ASSOCIATES

One Airport Place, Route 206 North, PO Box 2197 Princeton, New Jersey 08540 (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross / Blue Shield

- 13 **Dermatology**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(*Shore Memorial Hospital and AMNJ*)
- 14 **Tropical Diseases Transmitted to the U.S.**
- 21 **Hypertension: Detection Followup**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 16 **Diabetes/Insulin Pumps, Automated Pancreas**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 19 **Indications for Skin Biopsy**
12:30-1:30 p.m.—West Hudson Hospital
Kearny
(*West Hudson Hospital and AMNJ*)
- 20 **Pseudomembranous Enterocolitis**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)

NEUROLOGY/PSYCHIATRY

- Sept.
- 1 **Violent and Assaultive Patients**
9:15 a.m.-4:30 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 2 **Ongoing Child Psychiatry Case Conference and Lecture**
8:30-10:30 a.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 3 **Physical Activity and Cardiovascular Health**
- 10 **Hypertension**
- 24 **Patient Care: Update**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 8 **Psychiatric Emergencies and Use of Psychotropic Drugs**
1-2 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 8 **Antibiotics**
- 22 **Emergency Care**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 17 **EEG Technology and Practice Series**
7-9 p.m.—Middlesex General Hospital, New Brunswick
(*EEG Society of NJ and AMNJ*)
- 21 **DSM-III**
2 p.m.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)
- 26 **Pain—Twenty-First Annual Carrier Foundation Symposium**
9:15 a.m.-4:30 p.m.—Scanticon-Forrestal Executive Conference Center, Rt. 1, Princeton
(*Carrier Foundation and AMNJ*)
- 27 **Pain—Companion Workshop to Symposium**
9:45 a.m.-4 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 30 **Diagnosis of Depression in the 1980's**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- Oct.
- 8 **Medical Causes of Anxiety**

- 22 **BCT in Medical Illness**
- 29 **Foreign Medical Graduate Training**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 13 **Psychopharmacology**
2 p.m.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)
- 15 **Pediatric Developmental Diagnosis**
- 22 **3:30-7:45 p.m.—Carrier Foundation Belle Mead**
(*Carrier Foundation and AMNJ*)
- 20 **Laboratory Interpretations**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 23- **Adolescent Emotional Disturbance:**
- 24 **Therapy through Special Education (Workshop)**
9:15 a.m.-4 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 24 **Prevention of Mental Illness in Children**
8:30 a.m.-4:30 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)
- 28 **Medical Evaluation of the Dementias**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 29 **Hypnosis in Medicine and Other Allied Professions**
3:30-7:30 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)

PATHOLOGY

- Oct.
- 6 **Hematology**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)

PEDIATRICS

- Sept.
- 22 **Prevention of Atherosclerosis—Pediatrics Lecture Series**
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(*St. Joseph's Hospital and Medical Center and AMNJ*)
- Oct.
- 1 **Rheumatoid Arthritis in Children**
10:30 a.m.—Freehold Area Hospital
(*AMNJ*)
- 7 **Antimicrobial Therapy in Childhood**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 15 **Pediatric Developmental Diagnosis**
- 22 **3:30-7:45 p.m.—Carrier Foundation, Belle Mead**
(*Carrier Foundation and AMNJ*)
- 29 **Adolescent Emotional Disturbance:**
- 24 **Therapy Through Special Education (Workshop)**
9:15 a.m.-4 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 24 **Prevention of Mental Illness in Children**
8:30 a.m.-4:30 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)

- 27 **Breast Feeding and Its Role in Host Defense**
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(*St. Joseph's Hospital and AMNJ*)

RADIOLOGY

- Sept.
- 9 **Diagnostic Patterns in Chest X-Ray**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 13 **Visiting Professorship Program**
1:30-4:30 p.m.—St. Barnabas Medical Center, Livingston
(*St. Barnabas Medical Center and AMNJ*)
- 26 **Basic Echocardiography**
- 27 **9 a.m.-5 p.m.—Nassau Inn, Princeton**
(*The National Foundation for Non-Invasive Diagnostics and AMNJ*)
- Oct.
- 1 **Radiology of the Skull and Cervical Spine**
10 a.m.—Bally's Park Place, Atlantic City
(*New Jersey ACEP and AMNJ*)
- 24 **Advanced Echocardiography**
- 25 **9 a.m.-5 p.m.—Nassau Inn, Princeton**
(*The National Foundation for Non-Invasive Diagnostics and AMNJ*)
- 28 **Nuclear Cardiology**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)

GENERAL SURGERY

- Sept.
- 10 **Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- Oct.
- 8 **Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 31 **Surgical Manpower, Regionalization and Second Opinion**
8 a.m.-1 p.m.—Newark Beth Israel Medical Center
(*AMNJ*)

MISCELLANEOUS

- Sept.
- 10 **Perspectives in Aging**
- 17 **4-6 p.m.—Institute for Medical Research**
- 24 **Copewood St., Camden**
(*Institute for Medical Research and AMNJ*)
- Oct.
- 1 **Aging in Plants**
- 8 **Aging in Ciliates**
- 15 **Aging in Invertebrates I**
- 22 **Aging in Invertebrates II**
- 29 **Physiology of Aging in Mammals**
4-6 p.m.—Institute for Medical Research
Copewood St., Camden
(*Institute for Medical Research and AMNJ*)
- 21 **Malpractice**
1:30 p.m.—Trenton Psychiatric Hospital
(*AMNJ*)

Dr. Richard C. Bew

One of Atlantic County's prominent retired surgeons, Richard C. Bew, M.D., died at Shore Memorial Hospital on June 23. Born in 1907, and a native of New Jersey, Dr. Bew earned his medical degree from Temple University's School of Medicine in 1934 and pursued a career in surgery. He was a Fellow of the American College of Surgeons and the American Society of Abdominal Surgeons and had been director of the department of surgery at Shore Memorial Hospital for 28 years prior to his retirement in 1969. During World War II, Dr. Bew served aboard the carrier USS Bunker Hill and the attack transport USS Drew, both in the Pacific Theater.

Dr. Anthony J. Biunno

One of Essex County's senior members, Anthony Joseph Biunno, M.D., of Short Hills, died on May 23 at his home. A 1935 graduate of Georgetown University Medical School, Dr. Biunno established a practice in internal medicine in East Orange. In 1975 he retired from private practice and accepted a post as chief of medicine at the Veterans Administration Regional Office in Newark. He had been affiliated with St. Michael's Medical Center in Newark, St. Mary's Hospital in Orange, and the East Orange General Hospital. Dr. Biunno had been a member of the Academy of Medicine of New Jersey. During World War II he served with the medical department of the AUS for five years. Dr. Biunno was 71 years old at the time of his death.

Dr. Matthew J. Brozyna

The senior attending surgeon and an executive committee member of St. Mary's Hospital in Passaic, Matthew John Brozyna, M.D., died there on June 9. A native of Passaic, Dr. Brozyna had lived in Poland until 1939, the year he earned his medical degree from the University of Jagiellonian in Krakow. He came to the United States for internship and graduate training in surgery at St. Michael's Medical Center in Newark.

Following a tour of duty with the U.S. Army medical department in Europe during World War II, Dr. Brozyna joined the staff at St. Mary's Hospital in Passaic and established a practice in that town. He also was affiliated with St. Michael's Medical Center and Passaic General Hospital. Dr. Brozyna was a Fellow of the International College of Surgeons. He was 65 years old at the time of his death.

Dr. William M. Dawson

At the untimely age of 55, William McKinney Dawson, M.D., a member of our Middlesex County component, died on June 14. A graduate of the University of New York's College of Medicine, class of 1952, Dr. Dawson pursued a career in obstetrics and gynecology, becoming board certified in that specialty. He had been on the staff at the Roosevelt Hospital in Metuchen, Perth Amboy General Hospital and the John F. Kennedy Hospital in Edison.

Dr. Filippo DiSanto

Filippo DiSanto, M.D., a member of our Union County component, died on May 15. A native of Italy, Dr. DiSanto earned his medical degree from the University of Naples in 1949 and emigrated to the United States in 1959 for graduate study in pulmonary diseases at Staten Island Hospital and the Essex County Sanatorium at Verona and remained to practice in Elizabeth. He was affiliated with Alexian Brothers, Elizabeth General and St. Elizabeth Hospitals. Dr. DiSanto was only 56 years old at the time of his death.

Dr. Richard H. DuPree

On May 24 Richard H. DuPree, M.D., of Paulsboro died at Jefferson Hospital, Philadelphia, following a cardiovascular accident. Born in Kansas City in 1925, Dr. DuPree earned his medical degree from Georgetown University Medical School in 1948, and following completion of a residency in medicine and gastroenterology established a practice in Paulsboro. He was affiliated with Our Lady of Lourdes

Hospital in Camden and Underwood Hospital in Woodbury. He also had been an instructor at the Hahnemann Hospital and Medical School in Philadelphia. Dr. DuPree was a Fellow of the American College of Cardiology, a Fellow of the American College of Gastroenterology, a diplomate of the American Board of Internal Medicine and a member of the American College of Physicians. He was active in Medical Society affairs having been a member of the Membership Inquiry and Complaint Committee with Medicare and most recently chaired Reference Committee "C" at the Annual Meeting in May. Dr. DuPree served with the medical department of the AUS during the Korean conflict.

Dr. Edward F. Duschock

On June 18, Edward F. Duschock, M.D., a member of our Middlesex County component, died at Perth Amboy General Hospital where he had been a member of the surgical staff for over 25 years. A native of Perth Amboy, born in 1906, Dr. Duschock earned his medical degree from Glasgow University Medical School in 1938 and returned to the United States to take a residency in surgery at Cornell Medical Center in New York. He was active in civic affairs and had been staff physician to the Perth Amboy Department of Health and police and fire surgeon. Dr. Duschock recently was named "Man of the Year" by the Perth Amboy PBA and made an honorary member of the group.

Dr. Maurice N. Harris

One of Cumberland County's senior members, Maurice N. Harris, M.D., of Bridgeton, died on June 9. A native of Philadelphia, born in 1906, and a graduate of Georgetown University's Medical School, class of 1931, Dr. Harris was a diplomate of the American Board of Radiology. He had been director of radiology at Bridgeton Hospital and had been affiliated also with Jeanes Hospital in Philadelphia. He was a Fellow of the American College of Radiologists and a member of the Radiological Society of

Dr. Irving Hayman

A senior member of our Passaic County component, Irving R. Hayman, M.D., died on May 31 at Barnert Memorial Hospital, Paterson, where he was a member of the staff. Born in Carteret in 1911, Dr. Hayman earned his medical degree from the Medical College of Virginia in 1937 and pursued a career in anesthesiology at Lincoln Hospital in New York City, becoming board certified in that specialty. He was a Fellow of the American College of Anesthesiologists and had been affiliated with Preakness Hospital in Paterson as director of anesthesiology. Dr. Hayman was active in organized medicine and had been president of his county medical society and of the New Jersey Society of Anesthesiologists. During World War II he served with the medical department of the AUS in North Africa and in both the Sicilian and Normandy invasions. He was the author of several published articles in his field.

Dr. Frank J. Hughes

Frank J. Hughes, M.D., one of MSNJ's renowned members, died at his home on May 30 after a long illness. A native of Philadelphia, Dr. Hughes earned his medical degree from McGill University in Montreal in 1938 and came to New Jersey the following year to pursue a career in obstetrics and gynecology. He was a Fellow of the American College of Surgeons and of the American College of Obstetrics and Gynecology and was board certified in his specialty. Dr. Hughes had been on the staff of the Cooper Medical Center during all of his professional life and had been an instructor in obstetrics and gynecology at the University of Pennsylvania Medical School. His contributions to organized medicine were extensive. He had been president of his county medical society (Camden) and was a member of the Board of Trustees of the Medical Society of New Jersey for many years and its chairman for four years. He also was chairman of the Committee on Medical Student Loan Fund. He was a member and chairman of New Jersey's delegation to the AMA from 1967 through 1974 and had been the Governor's appointee to the New Jersey State Board of Control, Department of Institutions and Agencies from 1963 until 1979. In 1967 Frank Hughes was

received into the pontifical order of St. Gregory the Great, which is bestowed on those who "distinguished themselves by incontrovertible loyalty to Church, to God, and to fellowman, by virtue and good example and by their zeal in fulfilling their position in the arts and sciences." Dr. Hughes was 71 years old at the time of his death.

Dr. Stanley T. Jurewicz

A member of our Ocean County component, Stanley T. Jurewicz, M.D., died on May 25 at Point Pleasant Hospital where he had held appointment as an anesthesiologist. A native of Paterson, born in 1917, Dr. Jurewicz was graduated from Hahnemann Medical College, class of 1943, and after graduate training in anesthesiology accepted an appointment at Paterson General Hospital where he remained until moving to Point Pleasant Beach in 1955. He was a Fellow of the American College of Anesthesiologists and a member of the American Society of Anesthesiology. During World War II Dr. Jurewicz served with the medical department of the AUS.

Dr. Lawrence R. Krivit

On May 10 Lawrence R. Krivit, M.D., a highly regarded family practitioner (as well as a graduate engineer with a degree from Massachusetts Institute of Technology) and a member of our Somerset County component, died at his home in Watchung. Born in Jersey City in 1930, Dr. Krivit was graduated from the Medical College of Virginia, class of 1959 and pursued graduate training at Cook County Hospital in Chicago. He had practiced in Monroe and Westchester, New York before coming to Manville in 1978. Dr. Krivit was on the staff at Somerset Hospital and Medical Center in Somerville and was certified by the American Board of Family Practice. Just a week before his death, Dr. Krivit completed the final product of an invention he had been working on during his illness—a new microscopic staining technique. He was a member of the American Academy of Family Physicians and of the American College of Emergency Physicians. Dr. Krivit was a veteran of the Korean War.

Dr. James B. Mearns

On May 29, Dr. James B. Mearns of Hawthorne died at his home after a prolonged illness. A native of New Jersey, born in 1915, Dr. Mearns was graduated from New York University Medi-

cal School, class of 1947, and pursued graduate training in general practice at the French Hospital in New York City and Paterson General Hospital. He was a member of the staff at Paterson General and attending physician at the Holland Christian Home in North Haledon. During World War II, Dr. Mearns served with the U.S. Air Force.

Dr. Stasys Petrauskas

One of Union County's senior members, Stasys Petrauskas, M.D., of Elizabeth, died at his home on June 22. A native of Lithuania, Dr. Petrauskas earned his medical degree from the University of Vytautas (Lithuania) in 1939 and emigrated to this country in the early 1950s. He established a practice in general medicine in Elizabeth and became affiliated with Alexian Brothers and St. Elizabeth Hospitals. Dr. Petrauskas was 71 years old at the time of his death.

Dr. Robert G. Stineman

Robert G. Stineman, M.D., chief of medicine, chairman of the department of family practice, and former chief of staff at the Burdette Tomlin Memorial Hospital in Cape May Court House, died there on May 8. A native of Philadelphia, Dr. Stineman earned his medical degree from the Medical College of Virginia in 1949 and pursued a residency in medicine at Lankenau Hospital in Philadelphia and Pensacola Naval Hospital. He came to Cape May Court House in 1955 to establish a practice and, in addition to his other activities at Burdette Tomlin Hospital, was instrumental in developing the monitor bed unit and the inhalation therapy and physical therapy departments. He was active in organized medicine and had been president of his county medical society and a delegate to MSNJ's House of Delegates. Dr. Stineman was a charter member of the American Academy of Family Practice and a veteran of the Korean War. He was 60 years old at the time of his death.

Dr. Gustave Suffness

Gustave Suffness, M.D., of Elizabeth, died on June 19 at his home. A native of New Jersey, born in 1912, Dr. Suffness was graduated from St. Louis University Medical College in 1936 and pursued graduate training in peripheral vascular diseases. He was affiliated in that specialty with Alexian Brothers, Elizabeth General and St. Elizabeth Hospitals. Dr.

Suffness was a Fellow of the American College of Angiology. During World War II he had served with the medical department of the AUS.

Dr. Charles F. Turner

We just have learned of the death on March 17 of Charles F. Turner, M.D., formerly of Montclair and a member of our Essex County component. A native of Wilkes-Barre, Pennsylvania, Dr. Turner earned his medical degree at the University of Pennsylvania in 1929 and came to Essex County to practice general medicine. He had been affiliated with the Mountainside Hospital in Montclair, where he was a member of the attending staff and chairman of the medical board, and the Essex County Isolation Hospital and Community Hospital in Montclair. In 1979 he was a recipient of MSNJ's Golden Merit

Award indicating fifty years as a physician. Dr. Turner was a member of the Academy of Medicine of New Jersey and had served with the Army Air Force during World War I. He was 85 years old at the time of his death and had been residing in Sherman Oaks, California since retirement.

Dr. Arthur E. Tator

At the grand age of 94, Arthur E. Tator, M.D., of Summit died at his home of a heart ailment. A native of New York, Dr. Tator earned his medical degree from New York Medical College in 1909 and pursued a career in gynecology. He was a Fellow of the American College of Surgeons and had been on the surgical staff at Overlook Hospital in Summit. In 1959 Dr. Tator was a recipient of MSNJ's Golden Merit Award in recognition of his 50 years of practice as a physician.

Dr. David H. Ulmer

At the grand age of 96, David H. B. Ulmer, M.D., a member of our Burlington County component, died at his home on June 20. A native of Merchantville, New Jersey, Dr. Ulmer earned his medical degree from Jefferson Medical College, class of 1909, and went on to take graduate training in otolaryngology at the University of Pennsylvania. He was board certified in that specialty and had been affiliated with the Burlington County Memorial Hospital in Mount Holly. Dr. Ulmer was involved in organized medicine and had been a past-president of his county medical society. He was active in the American Academy of Ophthalmology and Otolaryngology and had been school physician for the Moorestown public schools for many years. In 1959 Dr. Ulmer was a recipient of MSNJ's Golden Merit Award in recognition of his fifty years of practice.

BOOK REVIEWS

Profile of the Residency-Trained Family Physician in the United States 1970-1979.

John P. Geyman, M.D., Editor. New York, Appleton-Century-Crofts, 1981. Pp. 68 (\$12)

This booklet contains a series of articles which have been reprinted from the *Journal of Family Practice* (Vol. 11, #5). John P. Geyman, M.D., Editor of the *Journal of Family Practice*, states in the introduction to the booklet that the "overall goal of this monograph is to describe the practice patterns, perceptions, and geographic distribution of

representative samples of residency-trained family physicians in the United States." The ten-year period during which the data have been accumulated represents the first decade of the existence of family practice as a formally recognized discipline—a period of extraordinarily rapid growth.

Utilizing similar survey instruments, reports of ten-year experiences are given by residency networks associated with the Medical College of Virginia, the University of Minnesota and the University of Washington. In addition, the booklet contains a report by a committee of directors of research of New York State family medicine residency programs and the results of a nation-wide

survey conducted by the American Academy of Family Physicians. In all, the data impressively record the progress the discipline has made in achieving its early goals, e.g., distribution of family physicians to "needy" areas, provision of comprehensive and continuous care and provision of sufficient residency training slots eventually to permit 25 percent of graduating medical students to enter family practice residency-training programs.

Perhaps the most interesting section of this booklet is the summary written by Robert Graham, M.D., who currently is Acting Head of the Bureau of Health Manpower in Washington, D.C. While agreeing that family practice has

made great progress, he outlines a series of prospective issues which must be addressed if family medicine is to grow in strength and solidify its position within the academic and practice world. Among these are the "competitiveness with other providers, cost effectiveness, intellectual base, practice viability, and second-order distribution questions."

This monograph should be required reading for all family practice educators, health policy planners and for those people who run the medical education establishments. Its data will surprise many of family medicine's detractors, particularly, those who wish to convince others that family practice is a "dying specialty," that family physicians don't obtain significant hospital privileges and that the residency-trained family physicians are dissatisfied with their training and with their mode of practice.

Frank C. Snope, M.D.

The Hospital Book

James Howe and Mal Warshaw. New York, Crown Publishers, 1981. Illustrated. Pp. 94. (Hardback—\$10.95; paperback \$4.95)

The purpose of this book is to acquaint a child with the mechanics of hospitalization. It describes, in mostly simple terms, why a hospital stay is necessary, what happens to the individual hospitalized, the personnel who run a hospital and the equipment used in a hospital. It also imparts to the reader how he will get better and his feelings during the process. Mostly it emphasizes the fact that hospitals are utilized only when necessary and early discharge is to be encouraged.

The strength of this book lies in the beautiful black and white photos which illustrate the content of the written material. The patients used in these photos

seem quite adjusted and many seem inordinately happy, which may allay the fears of the intended patient reader. Included in the contents are pictures of routine diagnostic equipment (stethoscopes, otoscopes, and so on) and more sophisticated equipment (x-ray machines and CAT scanners). Therapeutically, pictures are shown of routine syringes, IV fluid therapy, inhalation equipment and operating room setups.

The drawbacks of a book of this type would be the unnecessary anxiety created in a patient admitted for routine pediatric primary care, for example, hepatitis, opposed to those admitted for more esoteric care (cardiac surgery). Also, the text stresses the pronoun "you" which implies reading material applies to every reader. Perhaps a better approach would have been to use the phrase "patient" where applicable.

Frank C. Vanore, M.D.

RENT

Physicians or Medical Group wanted to rent space in Newark. Up to 2500 square feet available in this conveniently located two-story building. Second floor dental office will release their patient list for initial referrals.

Instant Practice.
(201) 481-5000

DELUXE CALIFORNIA CONTEMPORARY



ARCHITECTURALLY DESIGNED AND CUSTOM BUILT. **\$375,000**

FOR COMPLETE INFORMATION & APPT. TO INSPECT—CALL

ECKHART REALTORS

201-233-2222

223 LENOX AVE.

WESTFIELD, N.J.

OFFICE SPACE

Available for immediate occupancy in a beautiful, modern professional building, in Somerset, NJ.

Spacious on-site parking lot and building is located 5 minutes or less from St. Peters and Middlesex Hospitals.

Because of Unusual situation—Good rental offer on this suite.

If interested contact Gil Lehr (201) 846-4455 or 873-2306 (evenings).

OFFICE SPACE FOR RENT

Office space available next to a Dental Office in a new professional building located on Main Street, Manville, New Jersey. Somerset Medical Center is five minutes away. A town of 14,000 plus, presents an unusual opportunity for an immediately successful practice.

Call (201) 722-2928 for additional information.

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$17,500 to \$20,100 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

ASSISTANT MEDICAL DIRECTOR

for state agency. Salary open. Boards and Administrative experience preferred but not essential. Please write to Box No. 257 c/o JOURNAL MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.

NEEMA EMERGENCY MEDICAL —a professional association—

Emergency Medicine Positions—available with emergency physician group in PA, NY, NJ, VA, WV, KY, MD and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical

Suite 400

399 Market Street

Philadelphia, Pa. 19106

or phone

in Pa., (215) 925-3511

outside Pa., 800-523-0776

CLASSIFIED ADVERTISEMENTS

LOCUM TENES—Part time work wanted. Internist with gastroenterology training and ER moonlighting experience. Available July-September '81. Box No. 254, c/o JOURNAL MSNJ.

FAMILY PRACTITIONER—Board eligible; seeking group practice or partnership in Central NJ to begin August 1982. No obstetrics. Write to Catherine Sharkness, 6 Dartmouth Avenue, Apt. 2-A, Bridgewater, NJ 08807. Call (201) 526-9626 after 6 PM.

INTERNIST—31, married, seeking group or partnership in internal medicine. Graduate NJ Medical School, 1979. Board eligible. Available July 1982. Peter Schottlander, M.D., (201) 522-2000 or (201) 381-5440 evenings after 6 p.m.

M.D.—Board eligible, not yet licensed. Seeks position as assistant or hospital employment. Graduate Peking Medical College 1954. Write Box No. 259 c/o JOURNAL MSNJ.

RADIOLOGIST—Fully trained radiologist is available for part time or vacation coverage. Box No. 240, c/o JOURNAL MSNJ.

NEEDED—M.D.—Board eligible or certified internist-cardiologist to associate with group in rapidly growing area in Ocean County, N.J. Salary with eventual partnership. Please send curriculum vitae to: Box No. 261, c/o JOURNAL MSNJ.

NEEDED—OB-GYN—To join solo practice in South Jersey Shore area. Growing area one hour from Philadelphia. Write Box No. 250, c/o JOURNAL MSNJ.

WANTED—PRACTICE TO BUY—Established Internal Medicine Practice to purchase in Essex, Passaic, Morris or Union County. Telephone (201) 226-1606 after 7 PM.

WANTED—OFFICE EQUIPMENT—Examining tables and any other office equipment and supplies for use in general medical practice. Allan Lazar, M.D., P.O. Box J, Teaneck, NJ 07666. (201) 568-3742.

WANTED—TO RENT—Pediatrician interested in renting or sharing the office space in South Jersey area. Write Box No. 260, c/o JOURNAL MSNJ.

INFORMATION FOR MEMBERS—RATES:—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JOURNAL MSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

FOR SALE—GENERAL PRACTICE—Well established practice for sale. Retiring from general practice. Available immediately. (201) 725-1228.

FOR SALE—GENERAL PRACTICE—Union County. Thriving, established general medical practice. Will introduce and advise. Building also available with rental property. Close to hospitals and medical centers. Please call after 7 PM only (201) 654-5974, (201) 654-6706 or write and send C.V. to Box No. 256, c/o JOURNAL MSNJ.

PRACTICE FOR SALE—Englewood Hospital Area, Bergen County. Internal Medicine and Family Practice. Practice is large enough to support 2 physicians. Principals only. Building and equipment negotiable. Write Box No. 262 c/o JOURNAL MSNJ.

FOR SALE—PEDIATRIC PRACTICE—Pediatrician entering academic medicine. Thriving, varied practice, shore area. Opportunity to join as associate before acquisition. Practice easily expandable to two physicians. Purchase terms very negotiable. Write Box No. 258, c/o JOURNAL MSNJ.

FOR SALE—Home/Office/Practice. Established Pulmonary and Allergy practice. Five-bedroom colonial home in Elizabeth. Call (201) 352-1334 weekdays 10-12 AM Home (201) 352-5789.

FOR SALE—Home/Office. Excellent location and opportunity. 10 room physician's office and residence in prime year-round seashore community. Established over 30 years. Hospitals near-by. Physicians needed. Rental cottage, garden area, inground pool. (201) 899-0920.

FOR SALE—Residence/Office/Furnishings. Spacious office-residence and office furnishings for sale of recently deceased G.P. Small town location in a rural but developing area of northwestern New Jersey. Excellent opportunity for young family practitioner or internist. Call (201) 689-1705.

FOR SALE—Medical Office. South Jersey. 2 apartments, medical office building in doctor-shortage area. Close to Philadelphia. Phone (609) 467-0466 or write Mrs. S. Lintz, Box 157, Swedesboro, N.J. 08085.

FOR SALE—Professional Office Building. Irvington, NJ. Center of town, one block from Garden State Parkway and bus terminal. Modern brick, A/C, ten years old, ample parking, multiple office suites on two floors, separate entrance each floor, elevator. Call Mrs. Jaffe, Monday-Thursday (201) 399-7796.

OFFICE SPACE—Cherry Hill. Office available in an established medical building located in a high density doctor area. Ideal for psychiatrist or dermatologist since none is practicing in the area. Call (609) 429-2270 daily 'till 4 PM.

OFFICE SPACE—Elizabeth. Private medical building in prime location. Well traveled street, excellent exposure. 1150 square feet. Beautiful arrangement of rooms, presently furnished and carpeted. Central air. Parking lot. X-ray machine available. Call (201) 643-4444 weekdays 9 to 5.

OFFICE SPACE—Englewood. 1200 feet can be divided. Ideal for psychiatrists and surgical specialties. Two blocks from Englewood Hospital. Ample parking. Call (201) 568-1441.

OFFICE SPACE—Roxbury Twp. Morris County. Prime location on Rt. 10. Tenants include large pediatric group, lawyer, architect, realtor. One 1356 square foot suite available. \$10/sq. ft. including all utilities, two smaller office on lower level at \$7/sq. ft. offices. Ideal office for dentist, podiatrist, ob-gyn, ent. Air conditioning, carpeting, ample parking, easy access, storage available. Dr. Elliott Milgram (201) 584-9390.

ACAPULCO, MEXICO—Efficiency apartment directly on beach. Finest location. Kitchenette. Sleeps four. Balcony. Pool. Rent now by week or month for choice periods. (201) 992-3556.



works well in your office ...

NEOSPORIN® Ointment (polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

September 1981

Journal of
the Medical
Society of

New Jersey

Ethnic Aspects of Boxing
Paul T. Williams, M.D.

Childhood Cancer Survival
Statistics

B. R. Ryan, M.D.

T. R. Walters, M.D.

Rape

Diane K. Shrier, M.D.

Eye Screening in New Jersey
R. A. Dornfeld, M.D., et al.

Complete Table of
Contents on page 636

LIBRARY

U.C. SAN FRANCISCO

SEP 29 1981

The Library
Acquisitions Division
Univ. of Calif., San Francisco
San Francisco, Calif. 94143

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

***Check this list
against your
coverages***

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$7,500 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____

Symposium

Grand Rounds In Medicine: RECOGNITION AND MANAGEMENT OF THROMBOEMBOLIC DISORDERS

Symposium Objectives

The objective of this symposium is to provide clinically relevant information to aid the practicing physician in the recognition of patients with thromboembolic disorders and proper patient selection for the use of anticoagulant or antiplatelet therapy. Panel discussions will focus on actual case histories representative of management problems confronting the physician in private practice.

Symposium Co-Chairmen

Richard Gorlin, MD

Murray M. Rosenberg Professor
Chairman, Department of Medicine
Mount Sinai School of Medicine
Physician-in-Chief
The Mount Sinai Hospital
New York, New York

Louis M. Aledort, MD

Professor of Medicine
Vice Chairman, Department of Medicine
Mount Sinai School of Medicine
New York, New York

Symposium Accreditation:

As an organization accredited for continuing medical education, The Page and William Black Post-Graduate School of Medicine of the Mount Sinai School of Medicine (CUNY) certifies that this continuing medical education offering meets the criteria for ten (10) credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed.

Registration

For additional information and registration, call Ms. Jayne Gross at 800-223-8978/9 outside of New York State or 212-752-4530 in New York State.



THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



Officers and Trustees

PRESIDENT	Armando F. Goracci, M.D. (Gloucester)	Woodbury
PRESIDENT-ELECT	Howard D. Slobodien, M.D. (Middlesex)	Perth Amboy
FIRST VICE-PRESIDENT	Alexander D. Kovacs, M.D. (Union)	Scotch Plains
SECOND VICE-PRESIDENT	Frank Y. Watson, M.D. (Essex)	Montclair
IMMEDIATE PAST-PRESIDENT	Augustus L. Baker, Jr., M.D. (Morris)	Dover
SECRETARY	Arthur Bernstein, M.D. (Essex)	East Orange
TREASURER	Rudolph C. Gering, M.D. (Mercer)	Pennington

Trustees

CHAIRMAN	
William Greifinger, M.D. (1984) (Essex)	Belleville
Meyer L. Abrams, M.D. (1982) (Burlington)	Cherry Hill
Frank Campo, M.D. (1984) (Mercer)	Trenton
Douglas M. Costabile, M.D. (1984) (Union)	Murray Hill
John J. Crosby, Jr., M.D. (1984) (Hudson)	Jersey City
Anthony P. DeSpirito, M.D. (1982) (Monmouth)	Neptune City
Ralph J. Fioretti, M.D., (1983) (Bergen)	Rochelle Park
Palma E. Formica, M.D. (1984) (Middlesex)	Old Bridge
Harry W. Fullerton, Jr., M.D. (1982) (Salem)	Carney's Point
Sherman Garrison, M.D. (1983) (Cumberland)	Bridgeton
John P. Kengeter, M.D. (1984) (Ocean)	Toms River
Myles C. Morrison, Jr., M.D. (1982) (Morris)	Morristown
Michael R. Ramundo, M.D. (1984) (Passaic)	Clifton
Bernard Robins, M.D., (1983) (Essex)	Springfield

Councilors

FIRST DISTRICT	(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1984)	Cranford
SECOND DISTRICT	(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1983)	Newton
THIRD DISTRICT	(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Albert F. Moriconi, M.D. (1982)	Trenton
FOURTH DISTRICT	(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1984)	Haddonfield
FIFTH DISTRICT	(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Ronald M. Fisher, M.D. (1983)	Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982)	Hackensack
William J. D'Elia, M.D. (1981)	Spring Lake
Frederick W. Durham, M.D. (1982)	Haddonfield
Karl T. Franzoni, M.D. (1982)	Trenton
John S. Madara, M.D. (1982)	Salem
Henry J. Mineur, M.D. (1982)	Cranford
Myles C. Morrison (1981)	Morristown

September 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Julio C. del Castillo, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Dreptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.
Harold Arlen, M.D.
Alfonse Cinotti, M.D.
Stuart D. Cook, M.D.
Robert Dodelson, M.D.
Wm. A. Dwyer, Jr., M.D.
Norman H. Ertel, M.D.
A. Olusegun Fayemi, M.D.
Arthur Goldfarb, M.D.
Robert A. Goldstone, M.D.
Murray Kahn, M.D.
Monroe S. Karetzky, M.D.
Avrum L. Katcher, M.D.
Sidney Ketyer, M.D.
Bernard J. Koven, M.D.
Joel D. Levinson, M.D.
Henry R. Liss, M.D.
Robert M. MacMillan, M.D.
Geobel A. Marin, M.D.
Christopher M. Papa, M.D.
Victor Parsonnet, M.D.
Irwin Pollack, M.D.
Bernard A. Rineberg, M.D.
Edwin L. Rothfeld, M.D.
Benjamin F. Rush, Jr., M.D.
Morris H. Saffron, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Sheldon D. Solomon, M.D.
Lloyd N. Spindell, M.D.
A. Arthur Sugerman, M.D.
Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 929. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

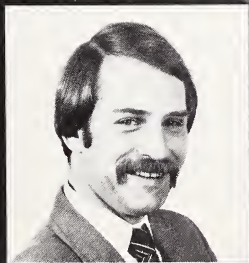
Larry Dlugolencki has become real friendly with medical assistant Fallon.

Larry is part of our special Blue Shield professional relations staff. Larry and his colleagues specialize in answering physicians' questions, and training their medical assistants.

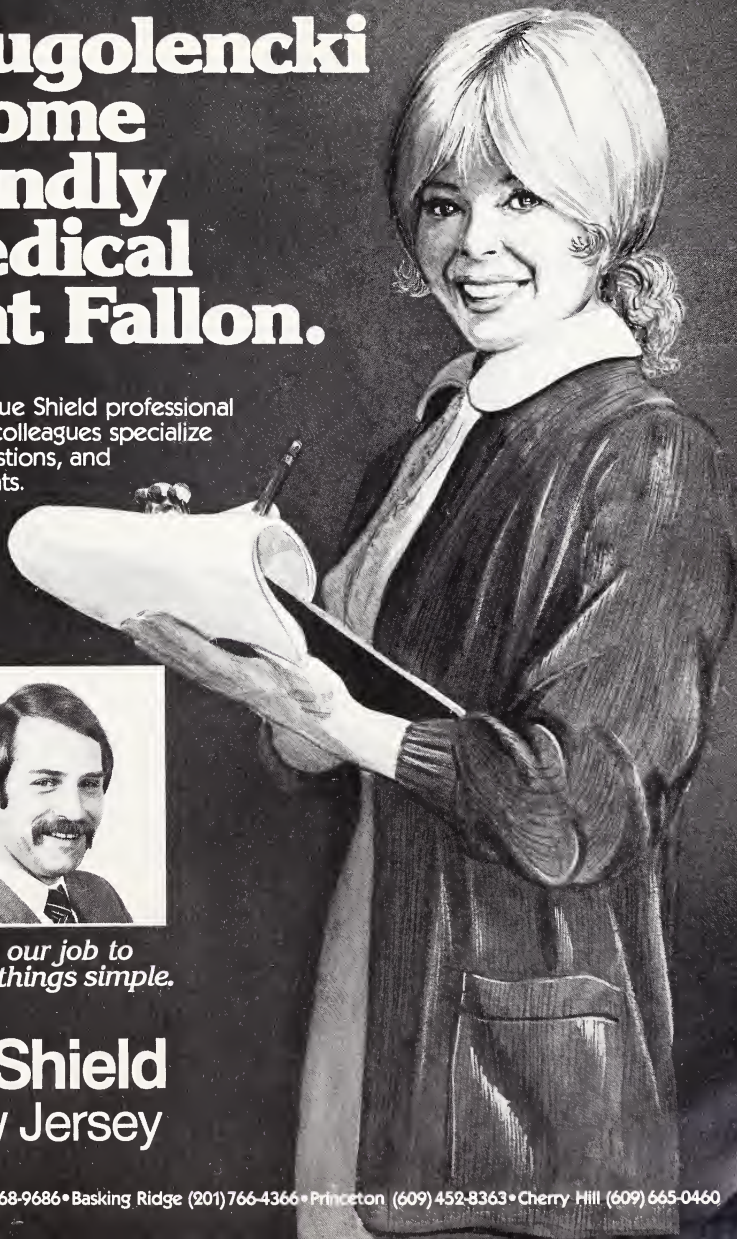
You can depend on our professional relations staff for quick answers to your inquiries regarding claims, billing information, and contract interpretation.

In addition, professional relations staff members handle the enrollment of new participating physicians.

So, next time you run into a Blue Shield related problem, call on us for the answer.



*It's our job to
make things simple.*



**Blue Shield
of New Jersey**

Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

641 **PROFESSIONAL LIABILITY COMMENTARY**

EDITORIAL

645 A Decade of HMO Experience

653 **JEMPAC REPORTORIAL**

ARTICLES

654 Ethnic Aspects of Boxing and the Ringside Physician

Paul T. Williams, M.D., Trenton

658 Childhood Cancer: Survival Statistics in a Pediatric Center

B. R. Ryan, M.D.; T. R. Walters, M.D., Newark

663 Cystic Medial Necrosis of the Ascending Aorta

L. N. Spindell, M.D.; H. Shah, M.D., Newark

668 Rape—Myths, Misconceptions, Facts and Interventions

D. K. Shrier, M.D., Montclair

673 Eye Screening in New Jersey

R. A. Dornfeld, M.D.; I.H. Jacobs, M.D.; A. A. Cinotti, M.D., Newark

CASE REPORTS

677 Unrecognized Bladder Diverticulum: A Cause of Persistent Urinary Tract Infection

D. J. Kissinger, M.D.; E. P. Beaugard, M.D.; P. S. Affuso, M.D., Teaneck

679 The "Silent" Acute Abdomen of Schizophrenia

J. T. Apter, M.D., Belle Mead

CLINICAL NOTE

681 Thrombosis of the Pampiniform Plexus

D. Rothman, M.D., Red Bank

682 **THERAPEUTIC DRUG INFORMATION**

683 **PEDIATRIC BRIEFS**

686 **COMMITTEES AND COUNCILS—1981-1982**

DOCTORS' NOTEBOOK

691 Trustees' Minutes: July 19, 1981

694 CMDNJ Notes

695 Recommendations of the Subcommittee on Nutrition, NY Academy of Medicine

695 Invitation To Join American Physicians Art Association

696 Physicians Seeking Location in New Jersey

699 **CME CALENDAR**

704 **OBITUARIES**

706 **BOOK REVIEWS**

Cover

The cover is an original drawing by Elizabeth Ruggles, a well-known teacher and artist in the Trenton area, formerly on the staff of the New Jersey State Department of Health.



When are Inpatients Outpatients? When they're in Recreational Therapy.

If you live within a 50-mile radius of our hospital, you've probably seen our specially constructed "Ironsides" van on its way to, or coming back from, a ballgame, theater, or shopping center.

Teaching patients to have fun is serious business for our Recreational Therapists and on most weekends and evenings Terry May (seen above), Joanne Fishman, or one of our other therapists, drives a small group of disabled people back into the outside world of the able-bodied.

Fun and games and a return to society are essential parts of a total rehabilitation program.



New Jersey Rehabilitation Hospital

Owned and operated by Moderncare Centers of America, Inc.

240 Central Avenue, East Orange, NJ 07018 • 201-673-1860

Berrrand J. Bensam, MD, Medical Director • Stanley Shepard, Administrator

Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities and the American Board for Certification in Orthotics and Prosthetics Inc.

Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white glossy

prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

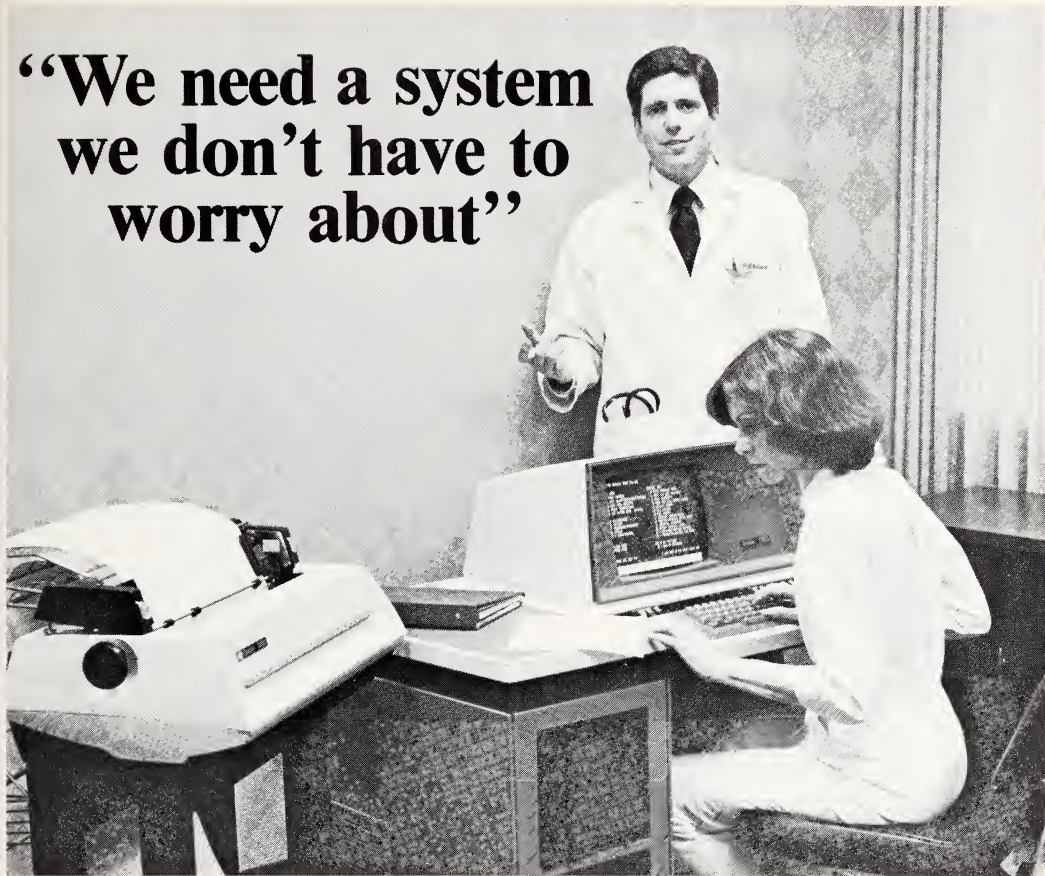
REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.

“We need a system we don’t have to worry about”



Dr. I. David Weisband, of the Regional Orthopedic Professional Association, is one of a growing number of physicians who've found Minicom's Medical Practice Management System meets the unique needs of a medical practice.

Automatic preparation of statements, Medicare and insurance company forms; instantaneous, up-to-the-minute accounts receivable information, plus a variety of practice analysis reports.

“We treat patients, not computers,” Dr. Weisband says, “so we need a system we don’t have to worry about.”

And our Medical Practice Management System is just that. It

features reliable Xerox Diablo equipment and is backed by our policy of Unsurpassed Service—hardware, software, training, maintenance and system back-up, all from one reliable source.

“Our office manager and accounting firm investigated alternatives,” he continues, “and recommended the Minicom system as the best solution to our needs. I agree.”

So, before you invest in a computer system for your practice, take his advice. Look into our Medical Practice Management System. Drop the coupon in the mail, or give us a call...and ask about US!

I'd like more information on Minicom's Medical Practice Management System.

Name

Address

City, State, Zip

Telephone (Area Code)

MNJ



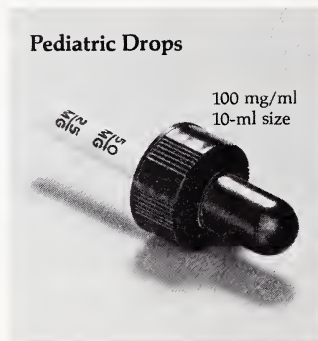
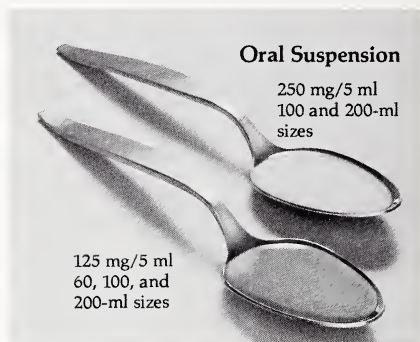
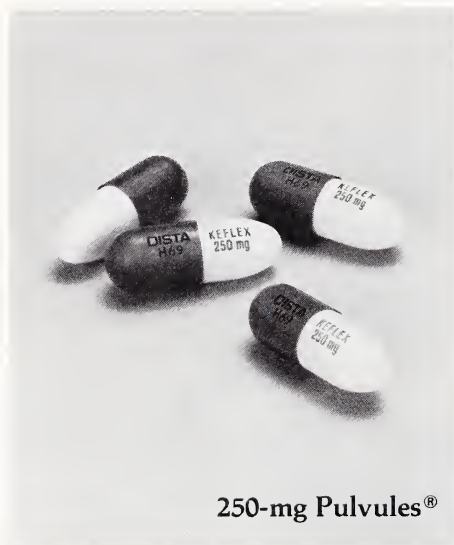
MINICOM

1415 E. Marlton Pike,
Cherry Hill, N.J. 08034
(609) 429-0600
(215) 925-6908

UNSURPASSED SERVICE

Distributors of Xerox business and professional computer systems.

easy to take



Keflex®

cephalexin

Additional information available
to the profession on request.



Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Featuring: NJ Supreme Court Overturns Appellate Decision Re Rule 4:21 Physician Panelists

NEW JERSEY SUPREME COURT UNANIMOUSLY OVERTURNS APPELLATE DECISION RE RULE 4:21 PHYSICIAN PANELISTS

In the August 1980 issue of *The Journal*, MSNJ (77:564) the "Commentary" reported on an appellate decision which would prohibit physicians with pending malpractice suits from sitting on *Rule 4:21* malpractice panels. The decision was appealed to the New Jersey Supreme Court which, in a 6-0 decision, overturned the Appellate Court's decision.

The majority opinion of the Appellate Division decided it was essential that each of the members of the panel be thoroughly impartial and free from influence of any factor that would affect or "would even create the risk of affecting impartiality." If a physician is a defendant in a pending malpractice action, there remains the risk that such a circumstance might have some influence "upon his ability to remain detached and disinterested . . . albeit unconsciously and unintentionally."

The New Jersey Supreme Court decision stated, "We believe that whenever a party objects to a proposed physician panelist because that physician is or has been a defendant in a malpractice action, or for some other valid reason, the judge presiding over the panel should determine whether the doctor will be able to maintain impartiality through all phases of the *Rule 4:21* hearing and any later trial proceedings . . .

"The presiding judge should make this determination on the basis of something more than the information concerning pending or past malpractice suits disclosed by the physician pursuant to *Rule 4:21-4(b)*. Specifically, the judge must conduct a session of careful, first-hand questioning of the challenged panelist in order to decide, based on the physician's demeanor and candor in answering questions as well as on any additional information revealed, whether that doctor will be an impartial panelist . . .

"In clear-cut cases, such as one in which a panelist is a party to, or was recently found liable in, a malpractice suit very similar to the one in which he has been asked to serve as a panelist, disqualification will certainly be in order. By contrast, an unsuccessful action against the panelist in the distant past will almost certainly not call for disqualification. Between such extreme cases, we trust that presiding judges will, by virtue of their specialization in this area as well as their judicial sensibilities, develop expertise in making these case-by-case determinations . . .

"Turning to the present case, the presiding judge, exercising his discretion, declined to disqualify the challenged physician panelist. However, the judge failed to question the challenged physician closely to determine if he could, notwithstanding his involvement in a pending malpractice suit, participate in the *Rule 4:21* hearing with impartiality. The judge apparently based his decision in this matter solely on the doctor's responses to the brief questionnaire submitted to

all *Rule 4:21* doctor and attorney panelists, and thus had no opportunity to make the careful assessment of impartiality that we deem necessary. While there is no reason to believe that the physician was anything less than impartial in the manner in which he participated in this proceeding, fairness to all parties requires that the case be remanded for a *de novo* hearing before a *Rule 4:21* panel composed of three new members.

"Consequently, while we disagree with the holding announced by the Appellate Division and the reasoning in support of that holding, the judgment of that court to remand the case for a hearing before a new *Rule 4:21* panel is affirmed, and selection of the physician member of this panel is to be conducted in accordance with the procedure that we have described."

CORRECTING SURGERY NOTES OF TRANSCRIPTION TYPIST

A physician's concern regarding typographical errors or omissions of medical terms in surgical notes prepared by hospital transcription typists was a topic presented in the "Practice Management" section of the May 1981 *Medical Economics*.

Physicians having this problem are advised to do the following: insert omitted words, correct all errors and initial each correction directly on the original transcript. It may be necessary to have the report retyped. On the second draft the phrase "corrected for typing errors" should be added. The physician should sign both copies and staple them together. The original will confirm that the report was made as soon as possible after surgery.

To assist in preventing errors the physician always should dictate slowly and distinctly, spelling any unusual medical terms. If there continue to be frequent errors the physician should inform hospital officials of the situation.

HOSPITAL NEGLIGENT IN GRANTING SURGICAL PRIVILEGES TO PHYSICIANS

The Wisconsin Supreme Court ruled that a hospital was negligent in granting orthopedic surgical privileges to a physician.

On July 11, 1975, the physician unsuccessfully attempted to remove a pin fragment from the patient's right hip. During the course of the surgery, the patient's common femoral nerve and artery were damaged, causing a permanent paralytic condition of his right thigh muscles with resultant atrophy and weakness and loss of function.

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

Fifteen months later the patient filed suit against the operating physician and the hospital. The physician settled the claim for \$140,000 and the patient proceeded with his action against the hospital. The claims against the hospital charged it with negligence in allowing the physician to perform orthopedic surgery.

A jury found the hospital negligent in granting privileges to the physician and apportioned 80 percent of the causal negligence to the hospital. Damages were awarded in the sum of \$405,000 for past and future personal injuries and impairment of earning capacity. An appellate court affirmed.

On appeal, the Supreme Court affirmed the decision and agreed that the evidence supported a finding of the hospital's negligence. A hospital owes a duty to its patients to use due care in the selection of its medical staff and the granting of specialized surgical privileges. The court said that in investigating medical staff applicants a hospital, at a minimum, should: require completion of the application and verify accuracy of applicant's statements, especially those pertaining to his medical education, training and experience; solicit information from applicant's peers, including those not referenced in his application but who are knowledgeable about his education, training, experience, health, competence and ethical character; determine if he currently is licensed to practice in the state and if his licensure or registration has been or currently is being challenged, and inquire whether applicant has been involved in malpractice actions and whether he has lost medical organization membership or medical privileges at any other hospital.

The hospital failed to perform these minimal requirements and its negligence caused the patient's injuries, the Supreme Court concluded.—*Johnson v. Misericordia Community Hospital*, 301 N. W. 2d 156 (Wis. Sup. Ct., Jan. 6, 1981)

A prior decision in this case was reported in *The Citation* 42:27, (May 15) 1981.

DID YOU KNOW

... A motion to increase the amount of damages sought in a malpractice and products liability suit should have been granted, a New York appellate court ruled. The suit, filed in 1972, sought \$500,000 for lowered visual acuity in a six-year-old girl, allegedly as a result of Diodoquin administration. When the motion to increase the damages to \$2,500,000 was made the girl had proved to be exceptionally gifted. The appellate court found that her intellectual capacity in 1979 could not have been established in 1972 and that the discovery of her unusually intellectual attainments presented new facts to justify the motion.—*Smith v. Adler*, 434 N.Y.S. 2d 457 (N.Y. Sup. Ct., App. Div., Jan. 5, 1981) ... *The Citation*, Vol 43, No. 3, May 15, 1981

... After many setbacks, doctors have won two strong victories against frivolous malpractice suits. Nevada's

highest court has upheld an \$85,000 award to an orthopedist who claimed that a plaintiff's attorney tried to coerce a nuisance settlement of \$750. The doctor refused to settle and countersued after a jury absolved him. And a California surgeon has won a \$175,000 verdict—\$100,000 of it in punitive damages—in his suit against a lawyer for malicious prosecution ... *Medical Economics*, May 25, 1981

... A Trenton, NJ jury awarded a 3.85 million dollar structured settlement to the widow and two children of a 40-year-old patient who entered the hospital for a circumcision, and became comatose.

... Massachusetts Medical Malpractice Joint Underwriting Association, which insures 70 percent of the physicians in the state, has requested a 60 percent rate increase retroactive to January 1, 1980. Present rates are far below what many physicians pay elsewhere. Of the 9,683 insured, 5,185 are Class 1 and presently pay \$98 for a first year claims-made policy of 100,000/300,000 coverage. The new rate would be at \$153. The mature rate for physicians in this class would rise from \$550 to \$861 (*Medical Economics* 6/19/81)

... A Chicago jury has awarded the biggest malpractice judgment ever—\$9 million—to a patient who was left quadriplegic and aphasic from brain hypoxia during cosmetic surgery. The defendants—a plastic surgeon, an anesthesiologist and their hospital—are insured for the exact amount of the award. The defendants' insurer could have settled out of court for \$4 million ... (*Medical Economics*, 6/22/81)

... In a June 13, 1981 letter to *The New York Times*, Albert Lewis, Superintendent of Insurance for New York State, claims there is no medical malpractice insurance crisis and takes exception to the New York physicians for attempting to create "hysteria." Mr. Lewis, in refuting the physicians, states that in the five and a half years of operation of both the Medical Malpractice Insurance Association and the Medical Liability Mutual Insurance Company \$640 million had been collected in premiums and only \$45 million has been paid out in claims.

INSURANCE FACTS

The Insurance Information Institute of California recently released the following report of California Superior Court verdicts concerned with medical malpractice cases for the period 1972-1980.

Several factors should be kept in mind as one pursues the chart: (1) The rise in the rate of inflation since 1972, (2) California's ranking as the most populous state (22 million), (3) California has the largest number of practicing physicians (58,000) and (4) California is known to be among the most litigious of states.

Year	Total No. Verdicts	Defendant Verdicts	Plaintiff Verdicts	Total Amount Awarded	Average Plaintiff Award
1972	137	82 (60%)	55 (40%)	\$11,016,305	\$200,296
1973	165	115 (70%)	50 (30%)	10,642,391	212,848
1974	215	142 (66%)	73 (34%)	9,768,628	133,817
1975	215	156 (73%)	59 (27%)	9,025,248	152,970
1976	226	168 (74%)	58 (26%)	9,661,795	166,582
1977	205	146 (71%)	59 (29%)	16,066,354	272,311
1978	204	147 (72%)	57 (28%)	11,456,873	200,998
1979	204	133 (65%)	71 (35%)	24,961,427	351,569
1980	180	110 (61%)	70 (39%)	21,607,739	308,682

for "cardiac separation"...



Although over 80% of post-coronary patients can resume normal marital sexual activity, fear of anginal pain often results in "cardiac separation" between patients and their families.

You can help minimize "cardiac separation" with a program of

counseling and often, with a prescription for Cardilate® (erythrityl tetranitrate).

Cardilate® increases exercise tolerance, helps patients return to more normal levels of activity—including sexual activity.

Sublingually, Cardilate begins to

work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to 2 hours.

counsel &
Cardilate®
(erythrityl tetranitrate)

CARDILATE® (ERYTHRITYL TETRANITRATE)

INDICATIONS: Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

CONTRAINDICATIONS: Idiosyncrasy to this drug

WARNING: Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Intraocular pressure is increased; therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrates and nitrites may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, epinephrine, histamine and many other agents. An occasional individual exhibits marked sensitivity to the pressor effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect.

Drug rash and/or exfoliative dermatitis may occasionally occur.

DOSEAGE AND ADMINISTRATION

Oral/Sublingual Tablets: Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg. prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED:

CARDILATE (Erythrityl Tetranitrate) TABLETS (Scored):
for ORAL or SUBLINGUAL USE: 5 mg. Bottle of 100
10 mg. Bottles of 100 and 1000. 15 mg. Bottle of 100.

Reference: 1. Hellerstein HK, Friedman EH. Sexual activity and the postcoronary patient. Arch Intern Med 125:987, 1970.

Burroughs Wellcome Co.,
Research Triangle Park, North Carolina 27709



**NEW YORK
FERTILITY RESEARCH
FOUNDATION, INC.**

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

**a group
Blue Cross/Blue Shield
plan for doctors**

Officially Endorsed by The Medical Society of New Jersey

**BROAD COVERAGE
COMPETITIVE RATES**

For More Information Contact
Donald F. Smith and Associates

1 Airport Place, Route 206 North. P.O. Box 2197 • Princeton, New Jersey 08540 • (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross-Blue Shield

A Decade of HMO Experience

In a recent editorial, N. T. Connally wondered whether the honeymoon between government and HMOs is over.¹ The dramatic change in attitude of the Reagan administration toward HMOs, as compared to the three prior administrations, was the stimulus for such questioning.

After a decade of development and experience in New Jersey, a look at Health Maintenance Organizations is in order. Are HMOs fulfilling the promises they once held? Are they a significant threat to the fee-for-service practitioner? How do participating and non-participating physicians feel about HMOs? Are HMOs helping to control costs?

IN THE BEGINNING

"On June 30, 1971, the New Jersey State Department of Health convened a statewide conference to discuss the potential benefits of prepaid group medical practice for New Jersey.

"This concept, a group of physicians offering medical services for a fixed fee, has become known as a Health Maintenance Organization or HMO."²

The avowed purposes of the development of HMOs was to alleviate the "health crisis" which was perceived in 1971 as "escalating costs, inadequate distribution of services and facilities, uneven treatment between the rich and the poor, and the absence of quality standards in health services."²

At the 1971 conference, State Commissioner of Health, James R. Cowan, reported "the creation of a special office within the State Department of Health which will devote itself exclusively to the development of health maintenance organizations." Cowan also announced: (1) "the award of a \$100,000 grant from the State Department of Health to the Mercer Regional group—specifically to foster the development of an HMO in the Trenton area," (2) the preparation of Certificate of Need guidelines for HMO development and (3) the likelihood of federal funds for feasibility studies and for development and planning grants. He urged all participants—representatives of government, fiscal intermediaries, providers (physicians and hospitals), industry, labor and the community—"to join us in the design of a blueprint for the next decade which must provide the finest health services—at moderate cost for all."

At the same meeting, Donald N. Logsdon, Coordinator of Health Maintenance Organizations, Region II, U.S. Department of Health, Education and Welfare, discussed HMO development in New York, New Jersey, Puerto Rico and the Virgin Islands. Logsdon spoke of the availability of federal grants and the award of two in New Jersey—a grant to the Hunterdon Medical Center and a contract with the Mercer Regional Medical group. He also described a gaggle of federal bills which were to provide financial assistance in one form or another for HMO development and summarized the

objectives of an HMO as follows:

1. To provide "one-stop shopping" for all necessary health care services for a defined population base as an alternative to utilizing the "cottage industry," (a reference to the existing medical care system). Specifically, HMO would be the technique for this purpose.

2. To provide more efficient incentives to decrease the cost by use of capitation payment, i.e., prepayment for service to an individual for a specified period of time.

3. To realize savings of 25 to 50 percent by decreased hospitalization and increased ambulatory care.

4. To provide the consumer a choice in a competitive industry based on price, not quality, because the quality of care is going to be the same whether it be under a prepaid system or a fee-for-service system.

5. To develop a system of consumer protection based on outcome evaluation eventually.

Logsdon's keys to HMO success depended on two principles: (1) the providers underwrite the risk of the system and (2) sickness is a liability to the HMO.

Raynor A. Fairty, then vice-president of Hospital Service Plan of New Jersey described the inner-city or suburban model of an HMO as serving the comprehensive health care needs of about 25,000 to 30,000 people (about 10,000 families) who live within 25 to 30 minutes driving distance of the HMO. Fairty predicted that emphasis on ambulatory alternatives through HMO would "move to prepaid group practice from 40 to 75 percent of the health dollar by bringing in unlimited medical visits to the facility and by emphasizing preventive aspects such as immunizations, well-baby care, and physical examinations." He envisioned a statewide "medical service corporation," which could satisfy the interests of organized labor, the principal carriers (Blue Cross, Blue Shield and Prudential Insurance Company), consumers, providers and state government (Health Department and Insurance Department).

Both Fairty and Harry Sutton, an assistant actuary of the Prudential Insurance Company of America, warned of the need for a massive "selling job" to convince employers and employees to adopt the HMO plan. Sutton frankly admitted his company was looking at HMO "as a business venture":

"We will commit ourselves to enrollment of HMO operations where we can get involved on a business-venture basis, although obviously the national problems of delivery of medical care are very important."

William J. Jones, then director of Medicaid in New Jersey, was "concerned about the total concept of HMOs being presented as a panacea," and added "I don't believe it is." He warned that "one of the dangers in HMO, as far as we in Medicaid see, is that the cost of medical care may escalate to a point where the Gross National Product can no longer

afford it and we then would be forcing ourselves into an undesirable national health insurance structure prematurely." Jones mused about the problems of eligibility and ineligibility of individuals for Medicaid assistance as an obstacle to participation of the Medicaid Program in contractual prepaid arrangements.

Jack W. Owen, president of the New Jersey Hospital Association, predicted that the HMO movement may cause "an actual decline of bed usage and occupancy rates" (in hospitals) and a need for increased outpatient and clinic facilities to take care of people who will be enrolled under a preventive program."

James A. Frazer, secretary of the Employees' Benefit Committee of the New Jersey Bell Telephone Company was concerned about a different issue:

"The inter-personal aspects of prepaid group practice, however, are not so bright as its technical performance. There is skepticism from many sectors. Complex facilities and large numbers of intermediate paramedical and administrative personnel sometimes have created a depersonalized atmosphere. It appears that the slow but steady increase in subscribers has come chiefly from persons who are dissatisfied with the traditional delivery system. So, at this point, I would not be able to say that the prepaid group arrangement is, or will be, necessarily the best delivery system."

Charles H. Ricciantie, president of the New Jersey State AFL-CIO, predicted a "massive swing from the present health care plans to the health maintenance type plan."

Albert J. Richter, assistant commissioner, Medical Services Administration of the U.S. Department of HEW, reviewed America's health gains in the period from 1950 to 1970, but was concerned about total health expenditures (1955: \$18 billion or 4.7 percent of the GNP; 1970: \$67 billion or 7.0 percent of GNP). He pointed to a rapid increase in government health expenditures from 25 percent in 1966 to 37 percent in 1970, two-thirds of which was federal money. Richter blamed increasing health care costs primarily on inflation with major increases in hospital charges and nursing home costs, with only a modest role for physicians' fees. Richter predicted per capita spending for health care rising from \$324 in 1970 to \$670 in 1980 with an increase to eight percent of GNP in 1980. He stated that seven million Americans were enrolled in HMOs in 1971 and he predicted that there would be enough HMOs in the United States by 1980 "to involve 90 percent of the population." Richter ended as follows: "I believe the developments in the field of health in the next few years will add up to the 1970s becoming the decade for better health."

THE NEW JERSEY EXPERIENCE

The New Jersey HMO experience and status as of 1980 were summarized recently by Shelley M. Ferrand.³ She stated that New Jersey enrollment in HMOs as of December 1980 was 158,887 enrollees in nine operating HMOs including two group, three staff and four Individual Practice Association (IPA) models. This figure should be compared with the mid-1980 national enrollment of 9,183,397 enrollees in 236 HMOs.

Ferrand pointed to "numerous issues that present an ongoing challenge to the HMO industry" (in New Jersey): benefit packages vary, there is a lack of available experienced HMO managers and "members of some HMO boards of directors have lacked the expertise needed effectively to set HMO policy and oversee operations." "HMO enrollment

through private employers accounts for 59 percent of the total New Jersey HMO memberships," while 36 percent of the enrollees come from the State Health Benefits Plan, which covers state government and participating county and municipal workers.

In New Jersey there is no Medicaid enrollment in HMOs, a fact which led the author to admit that "at this time they (HMOs) are not addressing the needs of the aged or the poor." This is due to the unwillingness "of government insurance systems to offer adequate prepaid reimbursement for the provision of HMO services for these special populations."

Although the federal government spent over \$300 million dollars to assist in HMO development since 1973, New Jersey HMOs were authorized to receive \$8 million dollars in federal grants and \$15 million dollars in federal loan assistance as of June 1980.

"As of December 31, 1980, there were more than 1700 physicians participating in New Jersey HMOs," in all three models, i.e., staff, medical group and IPA. These included full-time salaried physicians, part-time physicians paid by the hour and IPA physicians who receive a negotiated fee for service.

Hospitals are reimbursed for HMO plans by several arrangements: capitation agreements, the Blue Cross per diem rate or billed charges for fee for service. The introduction of the DRG system for hospital reimbursement has had a negative effect on HMO finances because DRG prevents HMOs from realizing savings in hospital costs due to shorter lengths of stay.

HMO has been credited with controlling health care costs by "drastically cutting the number and length of hospital stays."

Hospital Days Per 1,000 Members (1979)

N. J. HMO Subscribers	N.J. Blue Cross Subscribers	National HMO	Overall National Average
463.38	612	412	800

The problem with these statistics is that HMO subscribers and Blue Cross membership do not correspond in terms of age, sex or health status, while Medicaid and Medicare patients are not included in either. In New Jersey, the number of ambulatory encounters per HMO member was 4.43 in 1979 as compared with 4.5 for national HMO and 5.3 for the overall population.

The New Jersey HMO experience has not been all success, according to Ferrand. There were two total failures: Central Essex Health Plan and Group Health Plan of New Jersey (Hudson County). One IPA/HMO, Crossroads Health Plan, survived receivership and is being reorganized. Failures were attributed to fiscal difficulties caused by excessive hospital costs and poor management procedures.

As of 1980, HMO enrollment in New Jersey represents approximately "five percent of the total health care market in the State." Despite the slow progress of the past decade, Ferrand predicts a better future for HMOs in New Jersey.

HOW DO SOME NEW JERSEY PHYSICIANS FEEL ABOUT HMOs?

Although the majority of non-participating physicians in New Jersey have taken a "live-and-let-live" attitude about

HMOs, some express strong negative feelings:⁴

"The HMO concept as now functioning in Mercer County appears to be detrimental to the physicians of this county. At the same time it provides less than optimal care to many patients and totally ignores the medical needs of a significant part of the populations—needs that then must be provided for by the rest of the medical community. Care for the aged, poor and unemployable chronically ill must be provided by non-HMO physicians."

"At the same time that the closed-panel HMO abrogates these duties that should be the responsibility of every physician, it receives the benefits of greatly reduced laboratory and x-ray fees by the hospital (for which the private patient pays full fee)."

"False Blue Cross/Blue Shield advertising and government funding and loans, which may never be repaid, create unfair competition with private practicing physicians."

"The patient who needs care after 4 or 5 p.m. generally is referred to the emergency room to await the availability of the emergency room physician—another example of inadequately meeting patients' needs."

"HMOs are heavily funded to get started and heavily subsidized by the federal government and the New Jersey Blue Cross (in Mercer County) to continue operating. As a subscriber to Blue Cross and Blue Shield, I vigorously protest the use of my premium monies to promote unfair competition for the practice of medicine in this area."

"Most of the physicians in private practice have seen patients taken from their own offices and have been doubly penalized by having to support, through contributions to New Jersey Blue Cross/Blue Shield, an ill-conceived health program which after several years still is not approved or funded by federal government."

Some positive thoughts about HMO participating physicians include the following:

"The Plan rates highly in patient acceptability since most services are covered completely and the staff is knowledgeable and sympathetic."

"There is continuity of care with the person selecting a personal physician and continuing with that same physician, frequently for years."

"Services are not impersonal and have nothing in common with the hospital clinics."

The Mercer Regional Medical Group staff currently consists of 12 full-time and 34 part-time physicians; of the latter group, 23 serve as consultants. Essentially, all of the full-time, part-time and consultant staff physicians are diplomates of their respective specialty boards.

"Compensation for the full-time physician is good considering the base salary and fringe benefits. Physicians must be well pleased for the turnover rate for full-time physicians has been low."

"New Jersey Blue Cross is an HMO authorized to operate in the State of New Jersey. Blue Cross contracts for the delivery of medical services with the Mercer Regional Medical Group, PA in Trenton."

"We are aware of the printed material used by the marketing staff of Blue Cross describing benefits, the rules of the program, services not covered, and so on. No false statements appear in this literature."

"Federal certification does not necessarily imply a 'badge of honor.' It is a mechanism whereby an HMO can qualify for federal grant funds and guaranteed loans."

THE AMA POSITION ON HMO

The position of the Judicial Council of the American Medical Association on "advertising and HMOs" is as follows:

"It is not unethical for a physician to provide medical services to members of a prepaid medical care plan or to members of a health maintenance organization which seeks members (or subscribers) through advertising its services, facilities, charges or other non-professional aspects of its operation, as long as advertising does not identify, refer to or make any qualitative judgment concerning any physician who provides services to the members or subscribers." Publication by name of the roster physicians, the type of practice and biographical information is not a deceptive practice.

The attitude toward HMOs has been one of tolerance and recognition, but the AMA House of Delegates in June 1981 supported "the elimination of government funds for new start-ups of Health Maintenance Organizations and for the termination of funds for other HMOs after completion of the current funding cycle."

AMA NEWS 3/27/81

"HMOs are *not* the universal answer to health care delivery, but they never claimed to be. HMOs have demonstrated that they can meet the needs of many groups of patients."

"What is needed now is to allow existing HMOs to prove that they can make it on their own without large infusions of federal prop-up money."

"New HMOs should be started only in areas with clearly demonstrated needs (existing HMOs certainly favor this policy)."

In brief, the future of HMOs is limited only by their own ability to provide high-quality care at reasonable cost to all those who seek it—a challenge that must be met by any health care delivery system.

"If HMOs can meet such a test, they will silence the doomsayers. If they can do it without massive federal help, they will establish the HMO concept as a viable part of a multi-faceted national health care delivery system. The American Medical Association supports such a policy."

CONCLUSIONS

One must conclude, after a decade of HMO experience in New Jersey, that the crystal balls of most of the speakers at the HMO conference of June 1971 were a bit foggy. Cowan's special HMO office no longer functions.

There is little measurable evidence of cost containment and savings of 25 to 50 percent "by decreased hospitalization and increased ambulatory care." More patients have been infused into the health care system, while inflation and technological advances have caused additional increases in the national health expenditure and percent of gross national product from \$74.9 billions and 7.6 percent in 1970 to \$212.2 billions and 9.0 percent respectively in 1979. Instead of "immunizations, well-baby care and physical examinations," had Fairly selected and implemented obligatory use of seat belts, the 55 mile-per-hour speed limit, abolition of tobacco and elimination of drug and alcohol abuse, his prediction of cost savings would have been closer to the truth.

Marcianite's "massive swing" to HMOs has not occurred,

while Richter's prediction of 1700 HMOs by 1977 and enough HMOs by 1980 to handle 90 percent of the U.S. population was the prediction error of the century. Expenditure of \$300 million federal dollars to increase national HMO enrollment from seven million in 1971 to nine million enrollees in 236 HMOs in 1980 does not appear very commendable or cost effective.

One may come to many conclusions about HMOs in 1981, but William J. Jones was right—HMOs are not the panacea for health care that many predicted. It appears that the Reagan administration and the present Congress believe that, for the FY 1981 budget halves the Carter proposal for HMO assistance from \$56 million to \$28 million and the likelihood is a token authorization in FY 1982 and none by FY 1983.

New Jersey physicians should accept the fact that HMOs provide adequate health services to a limited portion of citizens. They are not superior to fee-for-service care and they have many faults. They may save some dollar expenditures for their enrollees. HMOs should be a part of a pluralistic American health care system. They do not appear to be a threat to the fee-for-service practitioner at this time. HMOs in fact may make all of us better physicians if we keep in mind some of the principles on which they are based:

comprehensive care, cost-containment, prevention, reduced hospitalization, increased ambulatory care, quality control and health education.

HMOs are here to stay, for whatever role they ultimately assume. If you don't want to join them, it is not necessary to fight them. Just recognize their deficiencies and their assets and use that information to make you a better physician.

A.K.

REFERENCES

1. Connally NT: Government and HMOs: Is the honeymoon over? *The Internist*. American Society of Internal Medicine, June 1981, p. 15.
2. HMOs. Proceedings of a Conference on June 30, 1971. NJ State Dept. of Health
3. Ferrand SM: Status report on New Jersey Health Maintenance Organizations (HMOs)—1980. *J Med Soc NJ* 78:457-462 June 1981
4. Doctor, What Do You Think? "What Is Your Opinion of the Mercer Regional Medical Group and Its Delivery of Health Care?" *J Mercer Co Med Soc* 13:14-17, June 1981.
5. Current Opinions of the Judicial Council of the AMA. 5.02 Advertising and HMOs. Chicago, AMA, 1981.
6. Actions taken by AMA House of Delegates—Annual Meeting. Chicago, June 7-11, 1981.
7. Source Book of Health Insurance Data, 1980-81. Washington, DC, Health Insurance Institute, page 21.



***You know
what you want
in Step-1
antihypertensive
therapy...***

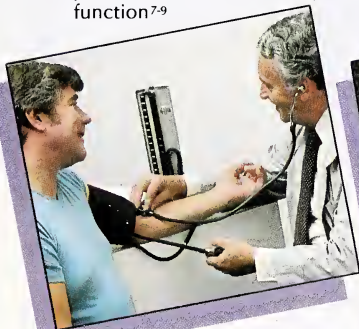
For your hypertensive patients,
Long-acting
Zaroxolyn[®] gives
(metolazone) Pennwalt

Efficacy

Start with Zaroxolyn because of its unsurpassed effectiveness in Step-1 therapy.^{1,4}

Stay with Zaroxolyn because it maintains effectiveness in long-term therapy^{1,5,6}... and minimizes the need for Step-2 agents.

- ☐ Zaroxolyn's effectiveness is maintained even in the presence of reduced kidney function⁷⁻⁹



Compliance

Stay with Zaroxolyn because it maintains 24-hour blood pressure control with simple once-daily dosage, and only 4% discontinue therapy due to side effects!



Safety

Stay with Zaroxolyn because clinically significant side effects are rare!

- ☐ Low incidence of changes in serum K⁺, glucose metabolism, or uric acid levels



you what you want

Compatibility

Add to Zaroxolyn easily if Step-2 agents become necessary.

- ☐ Permits lower doses of Step-2 agents to minimize side effects
- ☐ Allows flexible dosage titration, in contrast to fixed-dose combinations

Economy¹⁰

- ☐ Less expensive than most other diuretics
- ☐ More economical than hydrochlorothiazide in fixed-dose combination with triamterene or reserpine/hydralazine
- ☐ Costs less than beta-blockers
- ☐ Less expensive than methyl dopa, clonidine, or prazosin



Start with...stay with...and add to...

Long-acting

Zaroxolyn[®]

(metolazone)

Gives you what you want in
Step-1 antihypertensive therapy

Please see following page
for prescribing information.



Long-acting
Zaroxolyn[®]
 (metolazone) Pennwalt
 2½ mg, 5 mg, 10 mg tablets

**Gives you what
 you want in
 Step-1 antihypertensive
 therapy**

- ☐ Unsurpassed Step-1 efficacy in mild to moderate hypertension
- ☐ True once-daily dosage for excellent patient compliance
- ☐ Positive side effect profile
- ☐ Strong foundation for stepped-care therapy
- ☐ Long-term economy

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma, allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hyponatremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium

depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed), *Systemic Effects of Antihypertensive Agents*. New York, Stratton, 1976, pp 221-245. 3. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Fischett JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezzat E, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book* 1981, and manufacturers' suggested prices.

PENWALT
 DIVISION
 ROCHESTER, NEW YORK 14623

JEMPAC ATTRACTS GUBERNATORIAL CANDIDATES

JEMPAC invited 20 of the major candidates for Governor to meet with physicians and their wives at JEMPAC's Wine and Cheese Party, held during the Medical Society of New Jersey's 1981 Annual Meeting.

Candidates attending were Herbert Buehler, Frank Dodd, Ann Klein, Lawrence Kramer, Richard McGlynn, Barry Parker and James Wallwork. Candidates who sent representatives were John Degnan, James Florio, Barbara McConnell, Jack Rafferty, Robert Roe, and Joseph Sullivan.

In addition to the Wine and Cheese Party, the JEMPAC Breakfast attracted 85 physicians and their wives to hear Congressman James A. Courter. Congresswoman Marge Roukema had accepted JEMPAC's invitation to speak at the breakfast but just 48 hours before the affair she had to decline due to pressing business in Washington. Congressman Courter graciously consented to speak to our members as a last-minute replacement. His views on physician involvement as political activists has been the theme of JEMPAC since its inception.



MSNJ President Goracci and Congressman Courter.

NEW JEMPAC BOARD HOLDS FIRST MEETING

The reorganization meeting of JEMPAC was held on June 24, 1981 at the MSNJ Executive Offices. The newly elected officers of the Board of Directors are Frank Y. Watson, M.D., Chairman, Karl Franzoni, M.D., Vice Chairman, and William Ryan, M.D., Treasurer.

In accordance with the recently adopted JEMPAC Constitution and Bylaws, the Board of Trustees of MSNJ appointed the following to serve for three-year terms on the JEMPAC Board of Directors: William Allgair, M.D., Joseph Bocchino, M.D., Anthony Caggiano, Jr., M.D., Harold Colburn, M.D., Thomas Connolly, M.D., Karl Franzoni, M.D., Edward Luka, M.D., George Massell, M.D., Herman Robinson, M.D., Harold Scales, M.D., and Jeffrey Solomon, M.D. The Board of Trustees also approved the following at-large-members: Mr. Joseph Klein, Auxiliary Liaison, Robert Rigolosi, M.D., William Ryan, M.D., Allan Scher, M.D., and Frank Y. Watson, M.D.

Joseph Katz, Edward Meara and Clark Martin, MSNJ lobbyists, gave a brief overview of future political activities as they relate to the medical profession. Other business centered on how the district chairpersons could aid in recruiting and encouraging physicians to become active in physicians' political committees.

Also present at the meeting was AMPAC's representative, Mark Miller. He offered insight into the national political scene, and encouraged the members to attend the AMPAC Political Education Conference in Washington, DC on September 16-19, 1981.

The Board of Directors composed a set of questions to be submitted to gubernatorial candidates, Congressman James Florio and Mr. Thomas Kean, regarding their views on political topics. Responses will be published in a future issue of *The Journal*.



JEMPAC Board of Directors' Reorganization Meeting.

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

Ethnic Aspects of Boxing And the Ringside Physician

PAUL T. WILLIAMS, M.D. Trenton*

Ethnicity contributes to some important and hazardous problems of the boxer. An optimal athletic program should screen all participants for sickle cell trait, and despite a predictably low percentage of positives, special care and a specialist's attention sometimes are required to avert catastrophe.

The ringside physician who understands the sociological perspectives of ethnicity in the ring and other sports, will be better prepared with fresh and relevant approaches for the boxer's health care. There are several important health aspects of boxers which are directly and indirectly related to the ever-broadening role of the ringside physician.

An increased worldwide interest in boxing has caused an infusion of participants with mixed heritage from a variety of racial and religious backgrounds. The ringside physician should be aware of a preponderance of minorities as participants in the ring in America. This fact demands more attention to some specific and hazardous ethnic-oriented concerns.

KELOIDS

Keloid formation, a dense, fibrous tumor of the skin that occurs after injury, has a strong tendency to occur in black and other dark-skinned persons. A keloid extends above the surface of the skin and laterally and sometimes ventrally to involve areas that were not affected by the original injury.¹ After excision, the lesion may recur and possibly be larger. The scar tissue has little elasticity compared to the normal skin and it is susceptible to reinjury, especially in the first three months or the "active phase" of keloid formation. Thus, cuts and lacerations about the eyes of the boxer, the site of the most frequently encountered lacerations, must

have prompt and correct management to reduce the hazards of future injury and to reduce the possibility of situations which may shorten the individual's career.

A general plan for care of the usual laceration about the eye or eyebrow is listed below:

- (1) Continuous pressure may be applied, if needed, to stem the flow of blood.
- (2) The skin is cleansed and grease is removed with benzene or acetone.
- (3) The skin is prepared with an antiseptic after nerve blocks have been completed; do not shave the eyebrow.
- (4) The wound is irrigated with copious amounts of sterile normal saline. If normal saline is not available, tap water is suitable.²
- (5) The anesthetized wound is then explored to its fullest depth.
- (6) Dirt, hair, and other foreign bodies are removed.
- (7) The muscle, subcuticular layer and skin should be closed with accurate approximation, and non-traumatic handling of the tissues. All dead space should be obliterated. Fine suture material should be used.³
- (8) Complete x-ray examination should be obtained when

*Dr. Williams, a practicing surgeon, has been the physician for the Trenton Police Athletic League's highly successful boxing team for over 20 years, a member of the American Association of Ringside Physicians, and a physician for the New Jersey State Athletic Commission. Correspondence may be addressed to him at 40 Parkside Avenue, Trenton, NJ 08618.

the patient's condition permits. Wound irradiation, after appropriate consultation, may be indicated.

(9) The ringside physician must consider the need for prophylaxis against tetanus.

Both vertical and horizontal lacerations of the eyelids can produce serious sequelae. In vertical lacerations, notching and contracture can cause deformity if repair is not carried out carefully.³ Horizontal lacerations in the upper lid can result in division of the levator muscle causing a permanent drooping of the lid.

Repair of the eyelids requires careful approximation of the conjunctiva and tarsus in one layer using absorbable material. Knots must be placed external to the tarsus away from the conjunctival surface to prevent irritation of the globe. The orbicularis oculi muscle is then reapproximated after which, the skin is closed.³

In general, careful layer repair with 6-0 or 7-0 sutures, taking small bites, will suffice for the initial repair.³ Skin closure, with the edges in neat apposition and without tension, is of utmost importance. 5-0 to 7-0 nylon or silk sutures are suggested. This type closure for the majority of lacerations about the eye will help minimize keloid formation. Fortunately, that condition at this site is a rarity in boxers.

UMBILICAL HERNIA

Umbilical hernia is a true congenital defect, occurring through the patent umbilical ring following obliteration of the umbilical vessels after delivery. The hernia is present in 10 percent of Caucasian infants and in 40 percent to 90 percent of black infants. In most instances, the umbilical hernia has disappeared by the age of two, but a significant number persist into adult life, especially among the non-Caucasians. Incarceration, strangulation and even rupture of an umbilical hernia may occur, especially in the cases of blunt abdominal trauma, as may be encountered in the boxing ring.

The umbilical hernia in the adult always must be treated with the same dispatch used for treatment of the inguinal hernia, for it is liable to incarceration or strangulation or both.

Pre-fight abdominal examinations always should include inspection for umbilical herniation as well as for inguinal and other types of hernia. It is the responsibility of the ringside physician to disqualify any participant found with a hernia. After surgical repair, the athlete may be back in the gymnasium in four to six weeks.

SICKLE CELL TRAIT

Some authorities recommend that all individuals have examinations of the blood for sickling and for identification of sickle cell trait. Others have urged that all athletes, not just blacks, should be screened for sickle cell trait. It is not known what percentage of the non-black population may be carrying the sickle gene. It has been estimated that eight percent of the black population in the United States are carriers of this trait.⁴ Of particular importance among non-blacks is the fact that other forms of hemoglobinopathy could be of clinical importance especially if they occur in conjunction with the sickle trait.

Concerns have arisen because it has been found that red blood cells in the carriers as well as those with the disease *sickle* under conditions of hypoxia.⁴ Hypoxia may occur during strenuous exercise. Acidosis may occur in certain tissues during exercise enhancing sickling. When sickling

occurs, occluded small blood vessels appear in various parts of the body causing oxygen supply to be embarrassed with the rapid accumulation of metabolic end products that cause pain, cramping and damage to tissues and organs. When the sickle trait is present, acute symptoms are associated with an infarcted spleen or bloody urine.

The importance of the ring physician's knowledge of the presence of a sickle trait in an athlete should best be viewed from a preventive aspect rather than a prohibitive one. The presence of a sickle trait should not prohibit the participation in boxing or any other contest. But, it is definitely to the physician's advantage, and in the best interest of the fighter or contestant, to know beforehand if a sickle trait or an abnormal hemoglobin is present. This allows preparation for a sickle-cell crisis. It is impossible to predict a crisis or to cite the individual with the trait in which the sickle-cell crisis will occur. Particular attention should be given by the physicians and athletic trainers to preventing dehydration of an athlete with sickle trait.

After strenuous exercises such as may occur during rounds of hectic fighting, an individual with the sickle trait may be seized with painful episodes which may vary from a moderate one to an excruciating one that requires hospitalization and extensive therapy. Death has been known to occur during a painful episode or crisis.

Treatment should be immediate hydration with intravenous fluids and electrolytes; acidosis may be treated with intravenous bicarbonate. Intravascular coagulopathy may be treated with transfusions of fresh plasma, fresh blood and platelet concentrates.⁴

In the athletic population, it is a good idea to discover which athletes have had symptoms. The ring physician should ask, "Do you have cramps and pains in your abdomen or limbs after strenuous exercise?" He also should examine carefully for splenomegaly; an enlarged spleen is fragile and is subject to rupture following trauma.

One aspect of particular concern is episodic blindness which may occur in individuals with sickling disease, an ominous hazard to a fighter. Funduscopic examination may reveal abnormal fundi, but some sicklers and patients with abnormal hemoglobins may have a normal funduscopic examination.

The ringside physician should advise fighters and their trainers about the importance of a slow, graduated physical training program if high altitudes are involved so as to allow acclimatization. The change in available circulating oxygen at high altitudes may precipitate a crisis in those with a sickle trait; symptoms are nausea, vomiting, abdominal pain and muscle cramps.

The suggested test for screening all athletes—black and white—is the hemoglobin electrophoresis method. Screening and counseling always should be provided in an optimal athletic health program.

"After strenuous exercises such as may occur during rounds of hectic fighting, an individual with the sickle cell trait may be seized with painful episodes . . ."

Persons found to have the sickle trait should be referred to an ophthalmologist because abnormalities of the components of the blood can affect intraretinal circulatory dynamics. The earliest lesions of hemoglobin sickle cell disease are found in the extreme retinal periphery, an area that cannot be seen without special instruments.⁶ In these individuals, relatively minor trauma can initiate hemorrhage and often leads to retinal detachment. Surgery for retinal detachment in patients with sickle cell hemoglobinopathy, has a significant additional hazard and may cause ischemic necrosis to the anterior segment of the eye.⁶ Thus, any person with retinal eye signs associated with a hemoglobinopathy should be prevented from boxing for his own safety.

HYPERTENSION

Asymptomatic hypertension is one of the most common abnormal findings in the pre-fight examination.

Over 27 percent of the black population in America have hypertension as compared to 14 percent of the white.⁷ The hypertension death rate is 15 times higher for black men than white men.

Thirty percent of the Americans who have high blood pressure are unaware of it according to a study done by the National Heart and Lung Institute.

Accurate calibration of the sphygmomanometer (manometric or aneroid) is essential.⁸ Elevated blood pressure at any age increases the risk of cerebral hemorrhage, coronary occlusion and renal failure and decreases the survival rate in the event of a serious injury. Blood pressure of 150/90 mm Hg. or higher should be considered abnormal and followup is indicated.

The immediate observations indicated in the pre-fight hypertensive boxer should include basic historical data, information regarding medications and/or possible drug abuse, physical measurements, physical findings and possible influence of psychosomatic problems.

The physician should do a funduscopic examination on every hypertensive athlete because there are early retinal changes which can signal a course of action and suggest the prognosis. The retinal arterioles appear to narrow and the walls thicken. The vascular light reflex takes on a copper color and as more changes occur, it looks like a silver wire.

"... any person with retinal eye signs associated with a hemoglobinopathy should be prevented from boxing for his own safety."

Where the arterioles cross veins, the vein is obscured by the overlying artery. Partial venous obstruction occurs where the artery and vein cross causing a banking of the vein and an increased venous tortuosity.⁶ Other signs are fine linear hemorrhages and "cotton-wool" spots over the retina.

Later signs may show white waxy exudates often in a star pattern about the macula. As retinal edema progresses, true papilledema develops.⁶

The search for and the identification of these signs does not require an ophthalmologist, but consultation may be indicated. The funduscopic examination in special cases may help the ring physician to ascertain whether the contestant's hypertension may be due to nervousness or pre-fight tension and not to chronic hypertension, since only the latter is considered serious.

CONCLUSION

1. The ringside physician must know and understand the health problems of various ethnic groups.
2. An optimal athletic health program will include sickle cell screening for all participants, regardless of race.
3. A boxer with the sickle trait scheduled for a match in high altitudes (Denver, Mexico City, and so on) should be acclimatized adequately to avoid the danger of a sudden sickle-cell crisis which could result in serious injury or even death.
4. Genetic and general counseling should accompany screening when necessary.
5. All fighters should have a general medical pre-fight examination, including the abdomen; look for an enlarged spleen and herniation as well as other conditions.
6. The ringside physician may not be able to do a funduscopic examination on all athletes, but historical data and clinical findings should determine whether or not a referral to an ophthalmologist is indicated. A careful study of the eyegrounds may save the sight or the life of an athlete.
7. Repair of lacerations is done best in a medical setting.
8. Oxygen should be at ringside in the event of hypoxia and a crisis.

BIBLIOGRAPHY

1. Davis C, in Sabiston DC (ed): *Textbook of Surgery*, 11th Edition. Philadelphia, Saunders, 1977, p. 1661.
2. O'Donoghue: *Treatment of Injuries to Athletes*, 3rd Edition. Philadelphia, Saunders, 1976, p. 127.
3. Committee on Trauma, ACS: *Early Care of the Injured Patient*, 2nd Edition. Philadelphia, Saunders, 1976.
4. Ewing P, Jackson R, Murphy J, McCurdy P: Should sickle cell trait bar sports participation? *Phys Sports Med* 4:58-61, (Jan) 1976.
5. Ryan A: Sickle cell trait and sports. *Phys and Sports Med* 4:72, (Jan) 1976.
6. Feman SS: Retinal vascular disease. *Am Fam Phys* 10:147-149, (Oct) 1974.
7. Pollner P, Parish JJ: A high risk, hypertensive rural community. *J Natl Med Assoc* 68:471, (Nov) 1976.
8. Rakel RE and Conn HF (eds): *Family Practice*. Philadelphia, Saunders, 1978.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; J. B. Spanagolu, M.D. "Hormones for Improved Sexuality in the Male and the Female Climacteric." *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. mg. mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Childhood Cancer: Survival Statistics In a Pediatric Center

BEVERLY R. RYAN, M.D., THOMAS R. WALTERS, M.D. Newark*

Primary care physicians, parents and children with cancer desire the best care available. Clinical experience related to childhood cancer in a general pediatric facility was analyzed. The eventual outcome of these children was similar to that previously reported. Issues such as best care—equivalent care, referral pattern, the relationship of minicenters to cancer centers and the potential for carrying out protocol studies are raised.

It generally is accepted that pediatric patients with cancer should be treated at cancer centers. Frei stated that it is important, whenever possible, that leukemic patients be treated at major centers where the necessary personnel, expertise and sources have been marshalled.¹ Pinkel added that physicians' referral of patients with acute lymphoblastic leukemia (ALL) to recognized research centers for initial biological and clinical investigation will lead to optimal standard treatment.² D'Angio has commented that successful results can be achieved only at cancer centers.³ Meadows has commented that trained physicians in non-cancer center institutions can achieve good results by utilizing nationally known protocols; however, an additional observation is that when treatment by protocol is excluded from analysis, cancer centers achieve significantly improved survival.⁴ These statements suggest that best care is available only at cancer centers. Primary-care referring physicians and parents of children with cancer attempt to follow this advice. Not infrequently, for various reasons including economic and transportation problems, care at cancer centers is not available and physicians and parents may feel frustrated.

To determine whether care at a multidisciplinary facility such as ours would result in survival statistics comparable to current standards, we have analyzed our clinical childhood cancer survival results and compared the data with the literature.

MATERIALS AND METHODS

The Division of Pediatric Hematology-Oncology of the CMDNJ-New Jersey Medical School was established in 1969. From June 1969 to February 1980, 164 pediatric oncology patients were treated. Therapy was scheduled as follows: patients were entered into protocol studies (Children's Cancer Study Group or Inter-group) when eligible. If not eligible e.g., previous therapy prior to Division contact or no access of entrance into protocol, therapy was carried out according to protocol. If no protocol study was available, a treatment schedule was devised related to literature data, personal experience of the clinicians involved and/or recommendations from cancer centers derived from pilot studies.

RESULTS

Acute Leukemia: Seventy-five patients with acute leukemia were treated. Sixty-three had acute lymphoblastic leukemia (ALL) and twelve had acute myeloblastic leukemia (AML). There was an accrual range of one to fourteen

*Dr. Ryan is clinical assistant professor of pediatrics and Dr. Walters is professor of pediatrics, New Jersey Medical School, CMDNJ, Newark. This study was supported in part by a grant from the New Jersey State Department of Health Special Child Services Contract No. 81-79-CC. Correspondence may be addressed to Dr. Ryan, Children's Hospital of New Jersey, 15 South 9th St., Newark, NJ 07107.

Table 1
Acute Leukemia — N.J.M.S. — 1969-1980
Total Number of Patients

Year	ALL	AML
1969	1	
1970	4	
1971	1	
1972	6	
1973	11	3 (14)
1974	9	
1975	7	
1976	3	4 (7)
1977	9	
1978	6	2 (8)
1979	4	3 (7)
1980	2	
	63	12

In 10 year period (1970-1979): 72 patients treated
ALL: 60
AML: 12
Average per Year: 7.2
Median: 7 (range 1 to 14)

Table 2
Acute Lymphocytic Leukemia Results

Total no. of patients	63
Number evaluable	58
Number alive	35/58
Number alive, in remission	34/58
Number expired	23/58
Median duration survival time:	
Alive	53 mo., range 1-125 mo.
Expired	21.5, range 0.5 - 85 mo.

Table 3
Solid Tumor and Lymphoma Results

Tumor Type	Total	Number Evaluable	Alive Dead*	Survival Per Cent	Survival Time Median/Range (Mos.)
Neuroblastoma	17	15	8	60	51/7 - 108
Wilms*	14	12	11	92	55/10 - 131
Brain	11	9	3	33	13, 32, 50
Rhabdomyosarcoma	7	7	4	57	60, 69, 70, 80
Retinoblastoma	5	5	4	80	4, 6, 46, 50
Hodgkin's Disease	13	10	7	80	29/13 - 108
Malignant non-Hodgkin's	10	9	5	56	20/5 - 30

*No evidence active disease

patients per year (Table 1). Fifty-eight patients with ALL are evaluable, i.e., they were not lost to followup by relocating. Thirty-five (60%) are alive and in continuous complete remission, with a median duration of 53 months and a range of one to 125 months (Table 2). Despite reports of a poor prognosis in black children with ALL,² in our experience the response in black children, 10 of 19 (52%) in remission, was similar to that in white children, 23 of 49 (64%).

Survival Comparison: The percentage of children with ALL alive and without active disease compares favorably with presently accepted statistics of a five-year remission rate of greater than 50 percent. Currently the Children's Cancer Study Group defines a good prognostic group as those children presenting with disease between the ages of three and six years with an initial wbc < 10,000/mm³.⁶ Thirteen of fifty-eight patients would be considered in the good prognostic group by this criteria. Nine of thirteen (69%) remain in complete continuous remission one to 125 months.

The limited prognosis currently reported in AML with median survival of one year is reflected in our results.⁷ Twelve patients with AML were treated; 3 of 12 are in remission at 7, 9 and 9 months, 9 of 12 have died, with a median duration of survival time 8.5 months and a range of one to 28 months.

Solid Tumors and Lymphomas: Eighty-nine patients with various forms of solid tumors and lymphoma have been treated, 17 with neuroblastoma, 14 with Wilms' tumor, 13 with Hodgkin's disease, 10 with malignant non-Hodgkin's lymphoma, 11 with brain tumors, 7 with rhabdomyosarcoma, 5 with retinoblastoma and the remaining 12 with miscellaneous forms of cancer (Table 3).

In general, our results are similar to those reported in the

literature. The National Wilms' Tumor Study I reports a two-year disease-free survival time of 90 percent in Stage I Wilms' tumor and 80 to 90 percent in Stage II-III.⁸ Eleven of twelve evaluable patients are alive without active disease 10 to 131 months from diagnosis.

The two-year relapse-free survival (RFS) rates for rhabdomyosarcoma are approximately 85 percent for Stage I, 72 percent for Stage II, 60 percent for Stage III and 25 percent for Stage IV disease. Overall, this reflects a two-year RFS of 60 percent.⁹ Our survival was 57 percent alive and free of disease with minimum duration of followup of 60 months.

Unfortunately, the survival rates for neuroblastoma have not changed much over the past decade. Survival seems dependent on age at diagnosis, extent of disease and location of the primary. The two-year relapse-free survivals have been reported as 63 to 85 percent for Stages I, II and IVs, 37 percent for Stage III and 5 percent for Stage IV.⁹ We have had a 60 percent survival (7 to 108 months followup) with four of nine patients being Stage IV at diagnosis.

The survival statistics for retinoblastoma vary also with extent of disease, but with early diagnosis and treatment survival rates of 80 to 90 percent are achievable.¹⁰ Four of five patients treated are alive without evidence of disease.

Past statistics for non-Hodgkin's lymphoma have been in the range of 30 percent survival with longer survival reported for disease localized to the head and neck.¹¹ Recently, higher figures are being obtained using combination chemotherapy and radiotherapy. St. Jude Children's Research Hospital has reported 90 percent two-year disease-free survival for Stages I-II and 38.8 percent for III-IV giving an overall figure of 55 percent.¹³ Our figure of 56 percent reflects followup of five to 30 months in five patients (1 Stage I at diagnosis, 2 Stage II

and 2 Stage IV) who are presently free of disease.

The results in Hodgkin's disease, 8 of 10 alive (with 3 of 8 Stage III at diagnosis and 2 of 8 Stage IV) compare with an overall survival of 81.3 percent in the literature.¹² A recent publication cited a Stanford University study which is finding a five-year disease-free survival of 82 percent for Stage IA to IIIB using combined modality.¹⁴

Our brain tumor results, a 33 percent survival rate, are difficult to interpret since our eleven patients represent a heterogeneous group, some referred after recurrence of tumor. Five-year survival of 62 percent for cerebellar tumors, 42 percent for cerebral tumors and 5 percent for brain stem tumors have been reported.¹⁵

Osteogenic sarcoma and Ewing's sarcoma seem to have improving statistics with aggressive adjuvant therapy. Relapse-free survival at 18 months of over 55 percent has been reported with osteogenic sarcoma.⁹ Of two patients treated, one is alive without disease two years from diagnosis. In localized Ewing's sarcoma five-year RFS of 75 percent are reported.⁹ One patient with disseminated Ewing's sarcoma expired eight months after diagnosis.

DISCUSSION

These comparisons have limitations. Our patient numbers are limited. The survival statistics do not reflect age, histology and extent of disease. However, our objective was to establish whether children with cancer effectively could be treated at a multidisciplinary pediatric care facility vis-a-vis a cancer center. As previously mentioned, there are those who recommend all patients with cancer be treated at a cancer center.¹⁴ Realistically, this does not address a significant problem. Frequently in an urban environment there are patients who, for various reasons, predominantly socioeconomic, are nonmobile, but by the very nature of their disease require sophisticated comprehensive medical care.

The data presented raise several issues that need a broader base and further discussion. The survival time and cure rates presented are similar to those previously reported.⁶⁻¹⁵ The comparison would carry more impact if reproduced at other minicenters. As this is documented, referring physicians and parents can be assured that the equivalent of best care is available.

Another area of interest is access to protocols. Entering children into protocol studies allows the patient the opportunity of benefiting from experience of those who participated in the development of the protocol. The patient also has access to the evaluation of the protocol's current status and to the toxicity encountered. The relatively rapid acquisition of data resulting from study group participation is important for the development of better treatment programs and understanding of childhood cancer. Significant problems in pediatric oncology include the relationship of minicenters to cancer centers and the participation of minicenters in protocol studies.

In conclusion, we suggest that a pediatric oncology division can deliver equivalent care with results similar to those in the literature. It is our opinion that this can be achieved only through a multidisciplinary facility with access to protocols and updated analysis. The goal of pediatric

oncology should include not only cure of the patient's cancer but development of an intact individual into adulthood. Because of this, we firmly believe children with cancer should be cared for at a multidisciplinary pediatric care facility, or at a pediatric cancer center.

SUMMARY

It is not always possible to refer pediatric oncology patients to major cancer institutions. This report examines the outcome of 164 pediatric oncology patients treated over a ten-year period at the CMDNJ-New Jersey Medical School Program. Patient referral was from the immediate catchment area which commonly uses the services of the hospital for other pediatric problems.

Seventy-five patients were diagnosed and treated for acute leukemia. Twenty-three patients were treated for lymphoma; sixty-six for solid tumors. Treatment regimens were usually those employed in nationally recognized protocols.

Although the number of patients is limited, survival statistics compare favorably with those given in the literature for the various malignancies.

REFERENCES

1. Frei E III, Sallan SE: Acute lymphoblastic leukemia: Treatment. *Cancer* 42:828-838, 1978.
2. Pinkel D: The Ninth Annual David Karnofsky Lecture. Treatment of acute lymphocytic leukemia. *Cancer* 43:1128-1137, 1979.
3. D'Angio GJ: Late sequelae after cure of childhood cancer. *Hosp Pract* 15:109-121, 1980.
4. Meadows AT, Hopson R, Lustbader E, Evans AE: Survival in childhood acute lymphocytic leukemia (ALL): The influence of protocol and place of treatment. *Proc Amer Soc Clin Oncol* (Abs C-554) 20:425, 1979.
5. Walters TR, Bushore M, Simone J: Poor prognosis in Negro children with acute lymphocytic leukemia. *Cancer* 29:210-214, 1972.
6. Robison LL, Sather HN, Coccia PF, Nesbit ME, Hammond GD: Assessment of the interrelationship of prognostic factors in childhood acute lymphoblastic leukemia. *J Pediatr Hematol Oncol* 2:5-13, 1980.
7. Chard RL, Finklestein JZ, Sonley MJ, Nesbit M, McCreadie S, Weiner J, Sather H, Hammond GD: Increased survival in childhood acute nonlymphocytic leukemia after treatment with prednisone, cytosine arabinoside, 6-thioguanine, cyclophosphamide, and oncovin (PATCO) combination chemotherapy. *Pediatr Oncol* 4:263-273, 1978.
8. D'Angio GJ, Beckwith JB, Breslow NE, Bishop HC, Evans AE, Farewell V, Fernback D, Goodwin WE, Jones B, Leape LL, Palmer NF, Tefft M, Wolff JA: Wilms' tumor: An update. *Cancer* 45:1791-1798, 1980.
9. Maurer HM: Current concepts in cancer. Solid tumors in children. *N Engl J Med* 299:1345-1348, 1978.
10. Howarth C, Meyer D, Hustu HO, Johnson WW, Shanks E, Pratt C: Stage-related combined modality treatment of retinoblastoma. Results of a prospective study. *Cancer* 45:851-858, 1980.
11. Altman AJ, Schwartz AD: *Malignant Diseases of Infancy, Childhood and Adolescence*. Saunders, Philadelphia, 1978, p. 284.
12. Ibid: p. 263.
13. Murphy SB, Hustu HO: A randomized trial of combined modality therapy of childhood non-Hodgkin's lymphoma. *Cancer* 45:630-637, 1980.
14. Desforjes JF, Rutherford CJ, Piro A: Hodgkin's disease. *N Engl J Med* 301:1212-1222, 1979.
15. Farwell JR, Dohrmann GJ, Flannery JT: Central nervous system tumors in children. *Cancer* 40:3123-3132, 1977.

Cystic Medial Necrosis of the Ascending Aorta*

LLOYD N. SPINDELL, M.D. and
HEMENDRA SHAH, M.D., Newark

A primary classification of cystic medial necrosis of the ascending aorta is proposed which can serve as a useful interim model for correlating clinical aspects of the disease. It appears likely that future advances in chromosomal band identification techniques greatly will improve our understanding of the clinical heterogeneity of expression frequently associated with this disorder.

Cystic medial necrosis (CMN) of the ascending aorta (AA) is a distinct pathological process that is characterized histologically by varying degrees of interruption, rarefaction, and fragmentation of the elastic fibers in the aortic media.¹ Large focal cystic areas are formed in the aorta which are devoid of the elastic fibers and accumulate a basophilic ground-substance-like material.

With loss of the elastic support in the media, the muscle fibers become disoriented and enlarged with resultant weakening of the wall. CMN has a predilection for the AA but an identical process may involve the pulmonary artery, distal aorta, and large arteries.² The weakened aortic media leads to aneurysmal dilatation, aortic insufficiency and dissection.

There are two theories to explain the dissection:

1. The occurrence of a proximal tear of both the intima and of variable depths of the media which allows luminal blood to split the media longitudinally and circumferentially by the forces of left ventricular contractility. This process may be accentuated by potential hypertension.

2. Hemorrhage from the vasa vasorum which leads to an intramural hematoma and splitting of the media with or without secondary communication with the lumen via intimal tearing.

Cystic medial necrosis of the ascending aorta (CMN-AA) has been described in Marfan's syndrome and in other heritable diseases of connective tissues such as Ehlers-Danlos syndrome, osteogenesis imperfecta, Hurler's syndrome, and lathyrism.

CMN-AA AND MARFAN'S SYNDROME

The relationship of CMN-AA and Marfan's syndrome is still incompletely understood. *Although most patients with Marfan's syndrome have CMN, most patients with CMN do not have Marfan's syndrome.* The histopathological changes in the ascending aorta are similar but the genetic relationship appears imprecise because there is a clinical heterogeneity in the manner and variability in the degree of expression of the Marfan gene.

Suspicion of Marfan's syndrome is more appropriate in the presence of characteristic aortic dilatation, subluxation of the lens, and severe kyphoscoliosis with deformity of the anterior thorax than in the presence of a variety of minor diagnostic features such as mitral prolapse, myopia and arachnodactyly.³

A method of classifying patients with CMN-AA is proposed as follows:

METHOD

Type I—CMN-AA (Marfan's)

- A. Classical Marfan's syndrome
- B. Marfan's syndrome
- C. *Forme fruste*

*From the Department of Radiology, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, New Jersey 07112, where Dr. Spindell is director of diagnostic radiology and Dr. Shah is a resident in radiology. Correspondence may be addressed to Dr. Spindell at the Medical Center.

Type II—CMN-AA (non-Marfan's)

A. Known etiology, e.g., Hurler's syndrome, lathyrism, and so on

B. Idiopathic

The subgroups are defined as follows:

Type I-A—CMN-AA and any two or three *characteristic* features of Marfan's syndrome involving the

1. Ocular system
2. Skeletal system
3. Family history

with or without minor features of Marfan's syndrome.

Type I-B—CMN-AA and one *characteristic* feature of Marfan's syndrome involving the

1. Ocular system or
2. Skeletal system or
3. Family history

with or without minor features of Marfan's syndrome.

Type I-C—CMN-AA and minor features associated with classical Marfan's syndrome or minor features associated with Marfan's syndrome or familial history of minor features.

Type II-A—CMN-AA with known etiology, other than Marfan's.

Type II-B—CMN-AA with no known systemic disease, normal body habitus and no family history of major or minor stigmata of Marfan's.

DISCUSSION

The above clinical classification may be used as a basis for tabulating and correlating disease in *propositi* (persons whose lineage is being traced), first-degree relatives (parents, siblings, and offspring), and distant relatives. It is likely that new chromosomal band identification techniques will permit improved understanding of the genetic transmission of these subtypes and therefore of the clinical pleiomorphism.

The prevalence of classic Marfan's syndrome is four to six persons per 100,000 population. In the classic Marfan's syndrome with a determinable cause of death, over 95 percent are related to cardiovascular problems and the life expectancy is halved.⁴ The serious cardiovascular complications of aortic regurgitation, dissection and rupture usually occur when the aorta reaches six cm. in diameter.

Payvandi investigated nine patients with "Marfan's syndrome" and found aortic root dilatation in five relatives and mitral valve prolapse in eight.⁵ Surprisingly, none of the forty first-degree relatives examined had symptoms of cardiovascular disease and none had a murmur of aortic insufficiency. Ultrasound examination of the forty first-degree relatives revealed seven with aortic root enlargement and thirteen with mitral valve prolapse. In evaluating eighteen patients with the "Forme Fruste" variety, Emanuel discovered no first-degree relatives with classical Marfan's syndrome.⁶ Examination of 67 of 85 living first-degree relatives disclosed six patients with dilatation of the ascending aorta and a seventh who died with dissection of the ascending aorta.

Although Marfan's syndrome is transmitted as an autosomal-dominant trait, Fried and Krakowsky have described a probable autosomal recessive inheritance in a family, and Anbani has reported a variable expression of the Marfan's syndrome in monozygotic twins.^{7,8}



Figure 1—24-year-old male with CMN-AA, type I-C. Postero-anterior chest film showing a broadened convexity of the ascending aorta, a normal aortic knob caliber, and no abnormality of the descending aorta.

CLINICAL MANIFESTATIONS OF CMN-AA

Males more frequently are affected than females; there is an age distribution from the first to the sixth decades with a peak incidence in the third to the fourth decades.⁹ Patients may complain of shortness of breath, fatigue, exercise intolerance, and most will have auscultatory evidence of aortic insufficiency. When aortic insufficiency is severe, dissection should be considered present until proved otherwise. The pain of aortic dissection will be reported by only a few patients; most patients disclose only vague intermittent chest pain or none at all.

In patients over 40 years of age, it is difficult to distinguish chronic dissection secondary to hypertension or trauma and CMN-AA. CMN-AA is probably the most frequent cause of dissection in normotensive patients under 45 years.

In the absence of overt cardiovascular manifestations, the clinical spectrum of findings as tabulated under types I-A, I-B, I-C and type II-A warrant investigation of the aorta and heart by ultrasonography.

RADIOGRAPHIC FINDINGS

The heart usually reveals a left ventricular type of enlargement. The left atrium also may be enlarged in patients with moderate to marked aortic insufficiency. The aortic root is not seen until pronounced dilatation has occurred and frequently it is not visualized until aortic insufficiency or dissection is present. Visualization of the dilated ascending aorta is enhanced by the lateral or left anterior oblique view. The dilated aortic sinuses and aortic root occasionally may be appreciated on plain films by a very subtle increase in radiodensity within the cardiac silhouette at the level of the left atrium. The size of the ascending aorta is much greater in CMN than in cases of aortic insufficiency secondary to congenital or rheumatic valvular disease (Figure 1). Isolated rheumatic endocarditis of the aortic valve is rare.

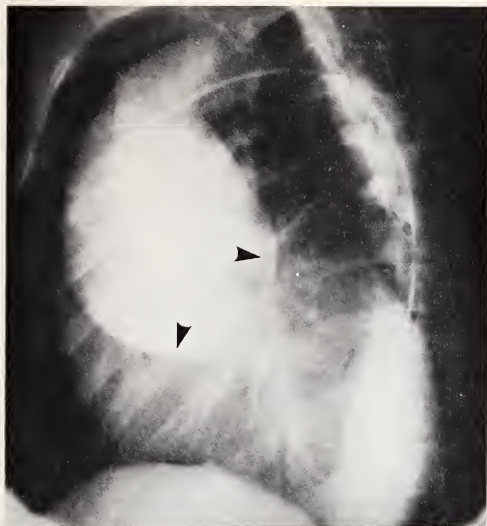


Figure 2—Same patient. Aortogram in right posterior oblique position demonstrating marked fusiform enlargement of the ascending aorta with abrupt transition at the level of the proximal arch. Note effacement of the aortic sinuses (arrows).

Cardiac fluoroscopy may show increased pulsation of the entire thoracic aorta which becomes more prominent with increasing aortic insufficiency. Eisen and Elliott also have described an unusual pulsation within the confines of the heart which parallels the outer aortic wall pulsations and has designated this phenomenon as the double pulsation sign of CMN-AA.⁹ The differential diagnosis of aneurysmal dilatation of the ascending aorta includes giant-cell arteritis, syphilis, Takayasu's arteritis, non-specific aortitis, idiopathic dilatation, autoimmune disorders, osteogenesis imperfecta, and lathyrism.^{10,14}

CARDIOANGIOGRAPHY

Characteristic signs of CMN-AA are symmetrical dilatation of the aorta and marked dilatation of the aortic sinuses (Figure 2). The aortic sinuses frequently dilate initially and sometimes asymmetrically with the dilatation extending along the ascending aorta up to the origin of the innominate artery. The dilatation then may end abruptly with return to normal caliber. Aortography is useful in demonstrating dissections which usually begin just above the aortic valve on the right anterior aspect. Despite dissection, the aorta maintains its symmetrical configuration in most cases. Another major type of dissection involves the entire thoracic aorta in a way similar to that demonstrated in chronic dissection resulting from hypertension and trauma.

In some patients, the dissection may be multifocal and highly variable. Patients with marked aortic insufficiency usually show a high incidence of dissection. Aortic dilatation correlates with some degree of regurgitation, but the extent of aortic dilatation does not correlate with dissection when the aorta is well margined and readily identified on plain films.

ULTRASOUND

Ultrasonography is an excellent modality for the documentation of the annulo-aortic ectatic aspect of cystic

medial necrosis. An aortic root diameter at end diastole of 4.2 cm. plus or minus 0.52 cm. was found to be statistically significant.¹¹ Abnormal motion of the aortic root is another clue to the diagnosis. In the normal patient, both anterior and posterior walls of the root show forward motion after maximum opening of the aortic valve as opposed to posterior paradoxical motion of the posterior wall.

The greater the paradoxical motion, the greater the dilatation of the aortic root which is suggestive of decreasing elasticity of the aortic wall. "Early opening" and partial premature aortic valvular closure also have been described but appear less specific. Atsuchi found paradoxical motion of the posterior wall in eight out of twelve patients and premature partial systolic closure of the aortic valve in all of the twelve cases.¹¹

MEDICAL TREATMENT

Propranolol has been recommended to retard aortic dilatation resulting from the anticipated decrease in left ventricular ejection impulse.¹² Treatment of patients with Marfan's syndrome and marked aortic dilatation with associated aortic insufficiency has proved disappointing presumably due to the late stage of therapy. Treatment of patients with only minimal dilatation of the aorta should prove more fruitful. The dose is administered four times a day and is augmented within the limits of clinical response. Children are treated in like manner. Prophylactic antibiotic treatment is recommended for patients undergoing dental procedures and urinary tract instrumentation because of possible endocarditis.

Decrease in myocardial contractility and not the reduction in blood pressure is considered the important factor in preventing dissection. The rate of rise of left ventricular pressure (dp/dt) is confirmatory of the decrease in myocardial contractility. Myocardial dysfunction and asthma are relative contraindications to the use of propranolol. Reserpine has been substituted for propranolol but it is less effective. In the presence of congestive heart failure, cardiac glycosides also may be intolerable because of the increase in left ventricular ejection impulse and potential additional trauma to the aorta.

SURGICAL TREATMENT

A decision to operate should be based on the degree of aortic dilatation, extent of aortic insufficiency, health and age of the patient. The major life-threatening complication is believed to occur when the aorta reaches six cm. in diameter, but even with this degree of dilatation, the mortality is estimated to be under ten percent if surgery is performed prior to a cardiovascular catastrophe or failure.¹³ Replacement of the ascending aorta alone has been unsuccessful because the proximal anastomotic line involves friable diseased tissue and the aortic sinuses continue to dilate. A new technique has been developed consisting of a composite graft which is formed by sewing a prosthetic valve into a woven dacron tube.¹⁴ The aortic valve leaflets are excised and the composite graft is anastomosed to the aortic root. The aortic ring is trimmed and sewn closely around the graft. The coronary arteries are then implanted into the graft.

A late complication is leakage of blood into the potential space between the external surface of the graft and the intima of the aorta. Leakage at the coronary artery anastomosis may be suspected by widening of the mediastinum. In demonstrating this leakage, cine angiography is considered a better modality than serigraphic angiography. Since the

leakage is a systolic event, cine permits a rapid succession of exposures and a greater chance of detecting the abnormality. Injection should be attempted both into the coronary lumen and around the insufficient coronary anastomosis.

Prosthetic replacement in children should be delayed as long as possible to avoid replacement by a larger prosthesis because of growth factors.

SUMMARY

Cystic medial necrosis of the ascending aorta appears related to the Marfan's "gene" in an imprecise manner. Improved understanding of the transmission of the disease will depend on information obtained from advanced chromosomal investigative techniques. Patients with cystic medial necrosis of the ascending aorta may be classified as follows:

Type I—Cystic medial necrosis of the ascending aorta (Marfan's)

A. Classical Marfan's syndrome

B. Marfan's syndrome

C. Forme Fruste Marfan's

Type II—(Other)

A. Known etiologies such as Hurler's, lathyrism, and so on.

B. Idiopathic

This classification can serve as an interim model for clinical and laboratory correlation of propo-siti, first-degree and distant relatives. Major life-threatening complications are believed to occur when the aorta reaches a diameter of six cm. Echocardiography is an important laboratory study for diagnosis and followup. A decision for medical or surgical therapy requires consideration of the health and age of the patient and the degree of aortic dilatation and insufficiency.

REFERENCES

1. Surek M, Eiseinstein R: Aortic lesion in Marfan syndrome. *Arch Path Lab Med* 101:74-77, 1977
2. Hurst JW, Logue RB, Sclant RC, Wenger NK: *The Heart*. New York, McGraw-Hill, 1978, 4th ed, pp. 1847-1851
3. Peyeritz RE, McKusick VA: The Marfan syndrome: Diagnosis and management. *N Engl J Med*. 300:769-777, 1979
4. Murdoch JL, Walker BA, Halpern BL, et al: Life expectancy and causes of death in the Marfan syndrome. *N Engl J Med* 286:804-808, 1972
5. Payvandi NP, Kerber RE, Phelps CD, Judisch GF, El-Khoury G, Schrott HG: Cardiac skeletal and ophthalmologic abnormalities in relatives of patients with the Marfan syndrome. *Circulation* 55:797-802, 1977
6. Emanuel R, Long RA, Marcomichelakis J, Moores EC, Jefferson KE, MacFaul PA, Wither R: Formes Frustes of Marfan's syndrome presenting with severe aortic regurgitation. *Brit Heart J* 39:190-197, 1977
7. Fried K, Krakowsky D: Probable autosomal recessive Marfan syndrome. *J Med Genet* 14:359-361, 1977
8. Ambani LM, Gelehrter TD, Sheahan DG: Variable expression of Marfan syndrome in monozygotic twins. *Clin Genet* 8:358-363, 1975
9. Eisen S, Elliot LP: Roentgenology of cystic medial necrosis of the ascending aorta. *Rad Clinc NA* 437-449, 1968
10. Case Records. *N Engl J Med* 300:1204-1209, 1979
11. Atsuchi Y, Nagai Y, Komatsu Y, Nakamura K, Shibuya M, Hirosawa K: Echocardiographic manifestations of annulo-aortic ectasia. *Am Heart J* 93:428-433, 1977
12. Halpern BL, Char F, Murdoch JL, Horton WB, McKusick VA: A prospectus in the prevention of aortic rupture in the Marfan syndrome with data on survivorship without treatment. *Hopkins Med J* 129:123-128, 1971
13. Davis Z, Pluth JR, Givliani ER: The Marfan syndrome and cardiac surgery. *J Thorac Cardiovasc Surg* 75:505-509, 1978
14. Nath, PH, Christoph Z, Wilfrido RC-Z, Guillermo V, Augustin F, Demetre N, Kurt A: Radiological evaluation of composite aortic grafts. *J Rad* 131:43-51

**NEW YORK
FERTILITY RESEARCH
FOUNDATION, INC.**

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

**a group
Blue Cross/Blue Shield
plan for doctors**

Officially Endorsed by The Medical Society of New Jersey

**BROAD COVERAGE
COMPETITIVE RATES**

For More Information Contact
Donald F. Smith and Associates

1 Airport Place, Route 206 North. P.O. Box 2197 • Princeton, New Jersey 08540 • (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross-Blue Shield

Rape—Myths, Misconceptions, Facts and Interventions

DIANE K. SHRIER, M.D., Montclair*

A view of rape as a crime of violence and a form of sexual deviation is presented to encourage a more supportive, less victimizing approach to the rape victim. Commonly held misconceptions about rape are countermanded by the available demographic data. The short-term and long-term psychological impact of rape on the victim and her family is discussed along with treatment recommendations. Protective measures to reduce the likelihood of sexual assault and a checklist for victims are included.

There continue to be numerous myths and misconceptions about rape—who gets raped, why they get raped, where and how rape occurs. Such misconceptions frequently prevent the rape victim from receiving the necessary medical, legal, and psychological support and care she requires to recover from the emotional trauma of the assault. Some of the more common *myths* include the following:

(1) The rapist is a sexually unfulfilled man carried away by a sudden uncontrollable urge. (2) Women are raped because “they ask for it” by dressing and walking seductively. The implication is that nice girls don’t get raped and that those who do get raped really want to be raped. (3) Rape occurs on the street by a stranger, generally a black man raping a white woman. The implication is that if women were more careful, stayed home, stayed out of dangerous neighborhoods they would not be raped. (4) Women are likely falsely to accuse men of rape. The implication is that many innocent men have gone to jail for rape.¹

For the most part the medical institutions, law enforcement and prosecutory system are based on these same myths—although fortunately the women’s movement has made some inroads for change. Even today in many states rape remains the only violent crime for which corroboration is required. The victim’s testimony is insufficient grounds for conviction and supporting evidence such as witnesses or proof of a struggle is required. One of the consequences of the corroboration requirement is that the victim is the one

who stands trial. I quote from an American Bar Association Committee report of 1937-38: “Today it is unanimously held by experienced psychiatrists that the complainant woman in a sex offense always should be examined by competent experts to ascertain whether she suffers from some mental or moral delusion or tendency, frequently found especially in young girls, causing distortion of the imagination in sex cases. . . .”² The law grants more protection to property than to the person, especially if the person is female. Imagine the cross examination of a robbery or mugging victim which parallels that commonly encountered by a rape victim: “In other words, Mr. Smith, you were walking around the streets late at night in a suit that practically advertised the fact that you might be a good target for some easy money, isn’t that so? I mean, if we didn’t know better, Mr. Smith, we might even think that you were asking for this to happen, mightn’t we?”³

In this paper, I will review some facts about rape, define rape and discuss the psychological impact rape frequently has on the victim and her family with some treatment recommendations. A perspective of rape as a form of sexual deviation will be discussed as well as possible motivating factors. Finally recommendations will be made for protective measures that can be taken to reduce the risk of sexual

*Dr. Shrier is clinical assistant professor, Department of Psychiatry and Mental Health Science, CMDNJ, New Jersey Medical School. She may be addressed at 543 Park St., Montclair 07043.

"... the typical rape victim is a poor, young, unmarried woman who is attacked by a member of her own race. Black women and other minorities are victimized at a greater rate than white women."

"... only 56 percent of the rapes discovered by the researchers were reported to the police. The highest risk age group for rape were women between the ages 16 and 24."

assault and a checklist to aid the rape victim will be presented.

DEFINITION OF RAPE

Rape legally is defined as carnal knowledge of a person by force and against that person's will. Two elements are necessary to constitute rape: (1) sexual intercourse and (2) commission of the act forcibly and without consent. The slightest penetration by the male organ constitutes carnal knowledge; neither complete penetration nor emission is required. Force may be defined as the use of actual physical force to overcome the victim's resistance, or the use of threats which result in victim acquiescence because of fear of death or grave bodily harm. Rape experiences encompass a wide spectrum, ranging from surprise attack with threats of death or mutilation to an insistence on sexual intercourse in a social encounter where sexual contact was not agreed upon. In fact, sexual violence is a frequent and unreported event in the usual dating situation on college campuses. From a psychological, as opposed to a legal point of view, rape is "an act of violence and humiliation in which the victim experiences overwhelming fear for her very existence as well as a profound sense of powerlessness and helplessness which few other events in one's life can parallel."¹

A recent study by the Criminal Justice Research Center in Albany, New York examined rape data and conducted interviews in 26 cities, including New York, Cleveland, New Orleans, Newark, and St. Louis.² They found the typical rape victim is a poor, young, unmarried woman who is attacked by a member of her own race. Black women and other minorities are victimized at a greater rate than white women. Most attacks are by strangers (most attacks about which anyone is informed are by strangers; attacks by husbands, boyfriends, family members, and friends of the family are even less likely to be reported than rapes by strangers). A large percentage of women do not report rapes and attempted rapes. In this study only 56 percent of the rapes discovered by the researchers were reported to the police. The highest risk age group for rape were women between the ages of 16 and 24. However, other studies have demonstrated that rape has occurred in children as young as two months of age, and in women as old as 82 years of age; also, men and boys have been raped (and not just in juvenile shelters or prisons). Males are probably even less likely to report having been raped because of the widespread belief that they should have been able to defend themselves and males are more likely to be seriously injured or killed during an attack whether or not they defend themselves.³ Women, on the other hand, who fight back reduce the chances that the rape will be completed but increase the chances of additional physical injury. Black and other minority women are victimized at almost twice the rate of white women: 115 rapes

per 100,000 persons for minority women as compared with 67 per 100,000 white women. The difference may be economic as the risk of rape decreases as the victim's income rises. In this study the most dangerous hours for attacks were between 6 p.m. and midnight and the most dangerous locations were open public areas such as streets or parks. One must remember that nearly half of these attacks were not reported to the police.² In contrast, in a study of rapes reported to police in the city of Philadelphia in 1958 and 1960, 56 percent of the rapes occurred in the victim's residence, so that it appears that rapes occurring in one's own home are more likely to be reported. Most attackers were alone and attacked women who were alone.

Until the last few years, it was not surprising that an estimated 50 to 90 percent of rapes were not reported to the police. The rate of arrest, prosecution, and conviction of rapists was extremely low and the victim often was traumatized by the interrogation by police and defense attorneys, as well as by the reluctance of medical personnel to expeditiously and supportively take care of her needs, and by the accusations of family and friends. In 1974, for example, only half of the reported rapes led to an arrest and 40 percent of the men arrested were never prosecuted; of the remaining 60 percent who were prosecuted half were acquitted or had cases dismissed. So, if there were ten rapes reported, only five would lead to an arrest and only three would be prosecuted; perhaps one would be convicted.⁴

The women's movement has been extremely active in the area of rape with the development of crisis intervention programs and education of lawyers, police, doctors, and nurses in the realities of rape. The change in some areas of the country including New Jersey since 1975 has been remarkable. In 1975 not one hospital in Essex County would admit sex crimes victims. They could be examined only by police doctors and women would have to wait up to 4 days unwashed to be examined. There are now three hospitals in Essex County (United, Mountainside, East Orange General) who will give immediate attention to rape victims by nurses, doctors, and police who are specially trained. There are seven special officers for sex crimes in Newark alone. The conviction rate for rapists in New Jersey is now up to 70 to 80 percent.⁴

PSYCHOLOGICAL IMPACT OF RAPE ON VICTIM AND HER FAMILY

Carol Nadelson and Malkah Notman have written extensively about the emotional repercussions of rape.^{5,6,7} They describe rape as "a crisis situation in which a traumatic external force breaks the balance between internal adaptation and the environment." As such, rape is similar to other catastrophic stresses such as community disasters, war and surgical procedures. Depending on the circumstances of the

rape, the victim's resources for coping and the reactions of the significant others in the victim's life, the acute stress reaction can lead to a traumatic neurosis. Rape is an overwhelmingly frightening and often life-threatening experience. It frequently creates a sense of helplessness in the victim and can result in prolonged feelings of shame, guilt, anxiety, impaired self-esteem, persistent feelings of vulnerability and interference with trusting relationships with men. As in most traumatic stress situations there is an immediate reaction and a longer-term reaction.⁶

Burgess and Holmstrom did a study of all rape victims in 1972-1973 seen in Boston City Hospital emergency room and reported the following: The immediate reaction to rape is usually anxiety, disbelief, and fear.⁸ There are two major categories of response—an expressed style and a controlled style. Those demonstrating the expressed style showed a massive overt response of crying, shaking, marked anxiety (hysterical reaction). Those showing the controlled style appear outwardly calm and collected but are really reflecting shock, disbelief and exhaustion. Fear of physical injury, mutilation and death and the awareness that they could have been murdered are much more prominent than focus on the sexual aspect of the crime.

The acute phase may last for a few days to weeks after the immediate shock reaction. This phase includes a variety of symptoms such as sleep disturbances with vivid nightmares and dreams in which there is an effort to master the trauma of the rape through reenacting it or handling it differently. Appetite disturbances and a variety of physical complaints are common. Fearfulness, difficulty concentrating, and concerns about reactions of others occur.

The second stage in which the victim begins to reorganize varies with the person's previous personality, available support system, and the way she is treated by others. The usual pattern includes changes in life style with impaired level of function at work, home and school. Many women move, others fear going anywhere alone and others give up autonomy by returning to their families. Sleep disturbances continue; sexual fears and loss of interest in sexual activities are common. Phobias appear with avoidance of situations resembling the one in which the rape occurred; panic occurs at unexpected physical contact or if anyone resembling the assailant is seen. The problems are compounded if the rape victim was a virgin or if the rapist was a trusted friend or relative. There is an attempt in this second phase of reaction to deny the impact of the rape on the victim's life and to reassure herself that everything is back to normal. This attempt to overcome anxiety contains a heavy measure of denial or suppression and is often a period of pseudoadjustment which does not represent a final resolution of the traumatic event and the feelings it has aroused.

The third stage is that of integration and resolution and may occur months or even years after the assault. In this phase depression is prominent along with a need to talk about and relive the incident with feelings of anger, guilt, fear, revenge, and self-blame.

In instances in which resolution of the crisis does not occur (probably in one-third of cases) the long-term consequences of the rape may include mistrust and avoidance of men, a variety of sexual dysfunctions, persistent phobic reactions, chronic anxiety and depression with problems with self-esteem.

The reactions of the mates and families of rape victims also can be very intense and may increase the trauma of the rape for the victim when they are unable to respond in an

empathic and supportive manner.⁹ Anger, feelings of resentment and criticism of the woman are common due to the strongly held misunderstandings and mythologies about rape which I mentioned earlier—nice women don't get raped, any woman who is raped must have wanted it. There is a romanticized view of rape in our culture deeply entrenched in myths, legends, the Bible, and masterpieces of art—beautiful voluptuous women being carried off and enjoying being ravished by handsome heroic men. The fact that so many women in our culture have fantasies of being raped has been misconstrued as evidence of their wish to be raped in reality rather than the fantasies being a psychic device to avoid responsibility for one's own sexuality.⁶ What one fantasizes happening is fortunately very different from what one wants in reality. In Erica Jong's book *Fear of Flying* her heroine Isadora Wing had frequent fantasies of a "zipless fuck"—an anonymous sexual encounter with a handsome stranger who would make passionate love to her and then leave. At the end of the book when such an opportunity arose with a handsome young train conductor she was totally outraged and threw him out of her compartment.¹⁰

However myths die hard and so the male mate of a rape victim frequently accuses her of wanting and causing the rape (asking if she enjoyed it, if the rapist was a better lover, and so on) and for the family to blame her and increase her guilt by accusing her of carelessness and seductiveness.⁹

Another attitude commonly expressed by boyfriends and husbands is the view of the woman as the property of her man so that they feel personally wronged. They now may see the woman as tainted and damaged merchandise, as unclean; this only seems to reinforce the victim's sense of humiliation and devaluation. In countries where virginity is highly prized the victim may be "unsaleable" in marriage, as happened in Bangladesh where thousands of rape victims were discarded by families and prospective mates. The mate and families often feel an intense sense of helplessness, rage and shock, a feeling as though they had been raped too. Along those lines, father, brothers and mates of the victim, in an attempt to protect themselves against the feeling of utter helplessness and impotent rage these males share with the victim, may threaten or attempt violent retribution against the rapist. Sometimes when the rape followed an argument between the victim and various family members, e.g., the victim stormed out of the house and put herself in a position of danger, there may be intense guilt and a sense of responsibility on the part of family.

Families often attempt to cope with the crisis precipitated by the rape by overprotection or by a conspiracy of silence both of which perform a disservice to the victim. In an attempt to assuage their own feelings of guilt and helplessness over their inability to protect the victim, families may insist on chauffeuring the woman everywhere or insist on her moving back to her parent's apartment if she is single. Such well-intentioned reactions only reinforce the victim's own sense of being helpless, defenseless and unable to cope rather than encouraging her sense of mastery and control. In other families a conspiracy of silence may develop with an attempt to keep the rape a secret from some members of the family or a refusal to have open ongoing discussion of the trauma. Such family "secrets" tend to become great burdens and destructive of potentially adaptive behaviors. The impact on the woman is to deprive her of the opportunity to mourn the personal loss inherent in her rape experience, deny her much-needed support and communicate the belief that "What's happened is simply too terrible to discuss" confirm-

“... a trained therapist in the immediate posttraumatic period can do a great deal toward enabling the victim to gain and maintain a sense of control and mastery.”

ing the victim's worst fears and doubts.⁹

THERAPEUTIC INTERVENTIONS

In the crisis produced by a rape, therapeutic intervention can make an enormous difference in the outcome for the woman.⁶ Short-term crisis intervention and often longer-term counseling, up to two years after the rape, can be most helpful. Through the pressure of the women's movement rape crisis intervention, medical, legal, and psychologic programs have been developed in which trained people are available as soon as the rape victim appears in the emergency room. To stick to the psychologic issues, a trained therapist in the immediate posttraumatic period can do a great deal toward enabling the victim to gain and maintain a sense of control and mastery. Since helplessness, fear, and humiliation are so prominent, it is important to help the victim restore her self-esteem and support her sense of competence. This can be done by explicitly letting her know how well she handled herself during the rape and in her attempts to cope afterwards—that she had done a good job and after all she is alive. Also, the woman should be given the opportunity to talk about the experience and her feelings as catharsis. Another important issue in the immediate crisis period is to mobilize friends and family support to help the victim feel less isolated, ashamed, and helpless. The ability of those in the woman's environment to support her will determine, in part, the extent to which continued therapeutic help becomes necessary. D.C. Silverman from Boston's Beth Israel Hospital, where extensive work has been done in rape counseling, advises that there are four important ways in which counseling interventions may enable family members and friends to provide a supportive environment for the victim's reconstitutive efforts.⁹ These include: (1) encouraging the open expression on the part of mates and family members of their affective responses to this shared life crisis; (2) facilitating cognitive understanding of what the experience of rape actually represents to the victim, i.e., that rape is experienced more as a life-threatening episode rather than sexual; (3) by educating the people close to the victim about the nature of the crisis she is experiencing and helping them to anticipate future psychological and somatic sequelae of the traumatic episode. This would include describing the rape trauma syndrome—that after a period of apparent outward readjustment there may be an emergence of nightmares, insomnia, somatic symptoms, anxiety attacks, phobias, depression, crying and feelings of fear, humiliation, anger and self-blame. Also, encouraging the family to empathically listen to the victim's feelings without reacting critically. Letting the family know that they can be most helpful by assisting the woman in mobilizing her own best coping abilities as an autonomous adult rather than a sheltered child; conveying strongly the idea that rape need not destroy the woman's

potential for normal functioning; (4) providing direct counseling services to individual family members whose personal responses to the crisis are so profound as to affect their ability to cope adaptively.

In addition to working with the woman and her family in a short-term crisis-oriented therapy, treatment should be made available on a longer-term basis as needed. In addition to restoration of prior functional level, the crisis experience can be used for genuine growth with the development of improved functioning and recognition of previous maladaptive patterns, such as counterphobic or counterdependent defenses.

THE RAPIST

Groth, Burgess and Holmstrom have developed an interesting perspective on the rapist and on the factors that motivate him to rape.^{11,12} Groth was a psychologist with the Forensic Mental Health Center in Massachusetts and Burgess and Holmstrom worked with sexual assault victims in Boston City Hospital Emergency Services. All three concluded that rape is a form of sexual deviation, a “pseudo-sexual act in which sexuality is used to express needs or wishes that are not sexual in nature and that jeopardize the physical and psychological safety of others.”¹¹ To support their thesis, these authors focus on the high incidence of the rapist's sexual dysfunction during the rape and on the apparent motivating factors for the rape.

In 1972-1973 Groth studied 170 men convicted of sexual assault and found that 34 percent had abnormal sexual function during the rape including 15 percent with retarded ejaculation.¹² The incidence of retarded ejaculation in the general population is 1 in 700. Similar sexual dysfunction did not occur with other nonassaultive consenting sexual relations but only in the specific context of the rape. One-third of the rapists were married and were having regular sexual intercourse with their wives. The majority of the single rapists had other regular sexual outlets. One might assume that convicted rapists are an unrepresentative sample since so few rapists are actually convicted, but studies of rape victims support the high rate of abnormal sexual dysfunction. In over one-half the cases of reported rape no sperm is detected in the victim.¹¹

As for the motivating factors for the rape, studies of both convicted rapists and rape victims revealed that, rather than rape being motivated by frustrated sexual desire, it represented the use of sexuality to express issues of power and anger.¹² Although issues of sexuality, power, and anger were present in all instances, it was possible to separate those assaults where power was the prominent issue and those where anger was the prominent issue with some differences in the degree of physical violence inflicted on the victim and the circumstances of the crime.

“... rather than rape being motivated by frustrated sexual desire, it represented the use of sexuality to express issues of power and anger.”

In *power rape* the rapist seeks power and control over his victim through intimidation. It is most often a premeditated, planned assault in which a victim is stalked. Threats and intimidation with a weapon are more common than physical brutalization with a focus on putting the victim in a helpless position where she could not refuse or reject him. The power rapist asserts his identity, potency, mastery, strength and dominance in an effort to deny his feelings of worthlessness, helplessness, vulnerability and sexual inadequacy.

In *anger rape* violent physical assault is characteristic with much more force being used than is necessary to overpower the victim. These rapes were typically unpremeditated or became an expression of revenge or retaliation for what the rapist perceived to be rejection and hurts inflicted on him by women in his life. Anger, contempt and hatred were expressed through physical violence, abusive language and forcing the victim to perform or submit to degrading acts.

PROTECTIVE MEASURES AGAINST SEXUAL ASSAULT

A person's life should not have to be circumscribed by fear of crime but in fact we live in a violent society and women are at greater risk for such violence. Women must be aware of their actions and surroundings at all times in order to reduce chances of becoming a victim of crime.

(a) At home:

- (1) Women who live alone should list only last name and initials in phone directories and on mailboxes.
- (2) Keep doors locked at all times.
- (3) Require identification of anyone who comes to the door.
- (4) Have adequate lighting inside and outside the house.
- (5) Have house key ready to open the door immediately.
- (6) If a window or door has been forced in your absence, do not enter or call out, immediately call the police from a neighbor's phone.

(b) Driving:

- (1) Keep doors and windows locked and travel on more populated, well-lit streets.
- (2) Keep car in gear when stopping at traffic signals. If safety is threatened, hold down on the horn and drive away as soon as possible.
- (3) If a car appears to be following you, drive to the nearest place where you can get help (gas station, police station, fire houses, and so on).
- (4) Never leave car unlocked even if you will be parked only a short time.

(c) Walking at Night:

- (1) If someone suspicious is nearby, cross the street, don't be afraid to scream and run.
- (2) If a car approaches you and you are threatened, scream and run in the opposite direction.
- (3) Walk near the curb and avoid dark doorways, alleyways, other places of concealment.
- (4) When arriving home by car or taxi, request driver to wait until you are inside.

CHECKLIST FOR VICTIMS

- (1) Report the crime immediately to the police.
- (2) Do not wash until examined.
- (3) Get a medical examination and treatment as soon as possible including documentation of injuries or bruises, semen smears, treatment for venereal disease and pregnancy.
- (4) Inform police of all details of the assault, including any information you may recall at a later date.
- (5) Give all stained or torn clothing, especially undergarments to the police.

CONCLUSION

Rape is a crime of violence and aggression of the most traumatic sort. Rape is the ultimate violation of the self, short of homicide, with an invasion of the inner and most private aspects of the individual as well as loss of autonomy and control.¹ In this paper some of the commonly held misconceptions about rape are presented and countermanded by facts about rape. The significant, and often long-term, psychological impact of rape on the victim and on her family is discussed along with treatment recommendations. A perspective on rape as a form of sexual deviation is presented and possible motivating factors of rapists described. Finally, some protective measures that can be taken to reduce the likelihood of sexual assault are suggested, as well as a checklist for victims.

This material is presented in an effort to increase the awareness of practicing physicians as to the traumatic nature of the rape experience and the need for supportive interventions with both the victim and her family in order to reduce the likelihood of long-term psychological damage.

REFERENCES

1. Hilberman E: *The Rape Victim*, Washington D.C., American Psychiatric Association, 1976.
2. McDermott J: *The Rape Victim*, Albany, N.Y., The Criminal Justice Research Center, 1979.
3. Johnson R: Workshop on Male Sexual Abuse. Conference on Prevention of Sexual Assault, Newark, N.J., November 8, 1979.
4. Murphy G: Keynote Address. Conference on Prevention of Sexual Assault, Newark, N.J., November 8, 1979.
5. Nadelson CC, Notman MT: Emotional repercussions of rape. *Medical Aspects of Human Sexuality* 3:16-31 March, 1977.
6. Nadelson CC, Notman MT: Psychoanalytic considerations of the response to rape. *International Rev Psycho-Anal* 97:97-103, 1979.
7. Nadelson CC, Notman MT: Psychological responses to rape. *Psychiatric Opinion* 4:13-22, July/August 1977.
8. Burgess AW, Holmstrom LL: Rape trauma syndrome. *Am J Psychiat* 131:981-986, 1974.
9. Silverman DC: Sharing the crisis of rape: Counseling the mates and families of victims. *Am J Orthopsychiat* 48 (1):166-173, 1978.
10. Jong E: *Fear of Flying*, New York, Holt, Rhinehart and Winston, 1973.
11. Groth AN, Burgess AW: Rape: A sexual deviation. *Am J Orthopsychiat* 47(3):403-406, 1977.
12. Groth AN, Burgess AW, Holmstrom LL: Rape: Power, anger and sexuality. *Am J Psychiat* 134:1229-1234, 1977.
13. Rape Safety Tips. Rape Awareness Coalition, Montclair, N.J., 1979.

Eye Screening in New Jersey*

RICHARD A. DORNFELD, M.D., IVAN H. JACOBS, M.D.,
ALFONSE A. CINOTTI, M.D., Newark

Formal eye screening programs have existed in New Jersey for over two decades. During this period over 490,000 individuals have been tested and 12,000 people have been identified as glaucoma suspects on followup examination. Twenty-five percent of the identified glaucoma suspects or 1.5 percent of the total number screened will have glaucoma. This figure is in agreement with published studies and confirms the impression that the eye screening programs in New Jersey are effective in identifying glaucoma patients and those at risk for developing the disease.

The value of early detection of open-angle glaucoma (OAG) is unquestioned. However, the effectiveness of large-scale screenings for disease in general,¹ or for this disease in particular is not without controversy.^{2,4} It is widely recognized that routine examination at regular intervals is most effective in the early detection of OAG because this disease is asymptomatic until late in its course, a factor which makes OAG the second leading cause of blindness in this country. Unfortunately, because of ignorance, poverty, unavailability of care and other reasons, eye screenings provide the only professional ocular examinations for many people. In an attempt to evaluate eye screening programs with special attention to glaucoma, this paper will discuss the epidemiology and pathophysiology of glaucoma and update previous reports concerning the experience of eye screening programs in New Jersey.⁵⁻⁸

GLAUCOMA—A HEALTH PROBLEM

Glaucoma is defined in its complete form as a triad consisting of increased intraocular pressure, abnormal cupping of the optic disc and visual field loss.⁹ The presence of two out of three findings is usually sufficient for its diagnosis.

The prevalence of glaucoma has been difficult to judge accurately.¹⁰ Values for the prevalence of open-angle glaucoma generally range from 0.36 to 2.0 percent of the population greater than forty years of age;¹¹⁻¹³ OAG accounts for about 90 percent of all cases of glaucoma.¹⁰

Epidemiologic studies have shown that factors which increase the risk for glaucomatous damage are: age, race, low blood pressure to intraocular pressure ratios, hypertensive medications and a family history of the disease.^{11,14,15} It is known that the elevated intraocular pressure leads to slow progressive damage of the optic nerve fibers over a period of years, perhaps secondary to a compromise of the blood supply to the optic nerve¹⁶ or to the backward bowing of the lamina cribrosa with consequent disruption in axoplasmic transport.¹⁷ The higher the intraocular pressure, the quicker and more likely damage will occur, although slightly elevated pressures have been found without glaucomatous cupping or visual field loss. These cases variously have been called ocular hypertension or preglaucoma and are considered by some to be a latent stage of the disease.¹⁷ The aim of screening is to identify those patients with ocular hypertension (latent stage) and those with true glaucoma (overt disease).

Recent estimates are that three million Americans suffer from glaucoma, but only 50 percent of these cases presently

*From the Lions Glaucoma Service of the Eye Institute of New Jersey and the Department of Ophthalmology, CMDNJ-New Jersey Medical School, Newark, New Jersey, where Dr. Cinotti is Professor and Acting Chairman, Department of Ophthalmology and Dr. Jacobs is Clinical Assistant Professor in the same department. At the time of this study Dr. Dornfeld was a resident in ophthalmology at the Morristown Memorial Hospital; he now is at Tufts University Medical School. Correspondence may be addressed to Dr. Cinotti at the Eye Institute, 15 South Ninth Street, Newark, NJ 07107.

Table 1
Medical Society of New Jersey "Eye Health Week"

Year	Number Screened	Positive Screening	Glaucoma Suspects	Patients Lost To Followup	Actual Glaucoma			Percent Glaucoma
					Definite	Borderline	Total	
1957	4,062	956 (24%)	260 (6.4%)					
1958	5,627	2,416 (43%)	328 (5.8%)					
1959	4,784	2,392 (50%)	298 (6.2%)					
1960	5,496	2,669 (48%)	362 (6.6%)					
1961	7,426	3,431 (46%)	405 (5.4%)					
1962	7,758	3,875 (50%)	529 (6.8%)					
1963	8,157	3,755 (46%)	467 (5.7%)					
1964	12,892	5,784 (45%)	684 (5.3%)					
1965	10,899	4,856 (44%)	532 (4.9%)					
1966	7,402	3,526 (48%)	404 (5.4%)					
1967	10,620	4,674 (44%)	576 (5.4%)					
1968	11,659	5,234 (45%)	561 (4.8%)					
1969	11,114	5,175 (46%)	464 (4.2%)					
1970	10,986	4,901 (45%)	456 (4.2%)					
1971	12,236	5,223 (43%)	504 (4.1%)					
1972	12,854	7,155 (56%)	593 (4.6%)					
1973	10,883	4,808 (43%)	579 (5.3%)	66	137	41	178	1.6%
1974	11,447	4,974 (43%)	546 (4.8%)	169	132	15	147	1.3%
1975	10,522	4,690 (45%)	581 (5.5%)	55	128	58	186	1.8%
1976	10,949	5,099 (48%)	589 (5.4%)	59	157	44	201	1.8%
1977	13,242	6,167 (48%)	750 (5.7%)	114	156	49	205	1.6%
1978	8,992	4,145 (46%)	495 (5.5%)	64	94	40	134	1.5%
1979	6,950	3,167 (46%)	349 (5.0%)	104	68	14	82	1.2%
1980	10,521	4,805 (46%)	471 (4.5%)	206*	76	21	97	0.9%
TOTALS	227,478	103,877 (46%)	11,783 (5.2%)	837	948	282	1,230	1.5%

* Followup attempts not yet exhausted.

are being treated.¹⁴ There are approximately 500,000 legally-blind Americans, of which 62,000 (13%) are blind from glaucoma. Glaucoma now ranks as the second leading cause of legal blindness in America, with another 160,000 patients suffering severe visual impairment and at least another 1.1 million having somewhat limited vision. Approximately \$436 million was spent in 1977 for direct treatment costs and \$1.9 billion was lost in production work time.¹⁸

In 1975 the National Society to Prevent Blindness screened 110,537 persons with 1,416 persons (1.3%) diagnosed as having definite or borderline glaucoma.¹⁹

EYE SCREENING IN NEW JERSEY

In New Jersey there are an estimated 65,300 persons with glaucoma in the thirty-five years and older age group.¹⁵ This implies that more than 30,000 unsuspecting individuals are at risk for progressive loss of vision in one or both eyes. Presently there are three programs established in the State of New Jersey concerned with eye screening:

(1) **Medical Society of New Jersey—"Eye Health Week"**—Since 1957 annual eye health screenings have been conducted each September by the Medical Society of New Jersey in conjunction with the New Jersey Academy of Ophthalmology and Otolaryngology, the New Jersey State Commission for the Blind and Visually Impaired, the Lions Clubs of New Jersey, the New Jersey Society to Prevent Blindness, the State Department of Health, and the New Jersey Hospital Association. These screenings are limited to individuals aged thirty-five and older and are staffed by volunteer ophthalmologists at 91 participating hospitals throughout the State. In the last twenty-four years this program has screened 227,478 people (Table 1). Of those screened, 46 percent were positive for either subnormal visual acuity, pathologic findings via ophthalmoscopy and/or external inspection or elevated intraocular pressure;

5.2 percent were considered to be glaucoma suspects. Eventually, 75 percent of these suspects were determined to have only ocular hypertension and the other 25 percent (1.5 percent of the total population) to have actual or borderline glaucoma. The followup of glaucoma suspects in this program is entrusted to the Eye Health Service Division of the New Jersey State Commission for the Blind and Visually Impaired. An excellent 92 percent followup rate of glaucoma suspects has been achieved by the use of letters, telephone calls, and home visits. The financial cost of this program is difficult to measure, but it is indeed minimal because an estimated 600 physician hours (or 300 screening hours), hospital-bound equipment and ancillary personnel all were provided on a volunteer basis.

(2) **The Lions' Eyemobile Foundation Program**—Started in June 1967, this program now directed by Mr. William Ferdinand of Berkeley Heights, New Jersey, provides ongoing eye screenings using three modified trailers. This program is funded by support from various Lions Clubs, fund-raising projects and individual donations. The screenings are performed by eye professionals, and there is no age limit to those individuals examined. The data in Table 2 show that the Eyemobile Foundation program is presently the largest single screening program in the State with 10,991 people being examined in 1980. To date, 117,883 people have been screened, with 30 percent of that figure failing for visual acuity, external examination, ophthalmoscopy or tonometry. Of the total screened, 1.8 percent were found to be glaucoma suspects by tonometry. The present annual operating budget is approximately \$35,000 and, therefore, the cost per screening is approximately \$3.

(3) **New Jersey State Commission for the Blind and Visually Impaired**—Through its Eye Health Service Division, this state-funded Commission has provided eye examinations since 1946 via a mobile eye unit which serves the public

Table 2
Lions Eyemobile Foundation Screenings 1967-1980

Year	Number Screened	Positive Screenings	Visual Acuity	External Examination	Ophthalmoscopy	Tonometry	Others Unknown
1967-72	41,016	15,061 (37%)	12,349 (30%)	3,134 (8.0%)	5,625 (1.3%)	540 (1.3%)	
1973	5,672	1,290 (23%)	243 (4%)	—	1 (0.0%)	214 (3.6%)	832 (15%)
1974	8,064	2,576 (32%)	1,448 (18%)	140 (1.7%)	260 (3.2%)	249 (3.1%)	479 (6%)
1975	13,144	2,899 (22%)	1,814 (14%)	118 (0.9%)	259 (1.2%)	187 (1.4%)	521 (4%)
1976	8,482	2,133 (25%)	1,677 (20%)	98 (1.2%)	210 (2.5%)	134 (1.6%)	14 (.1%)
1977	11,050	3,000 (27%)	2,020 (18%)	194 (1.8%)	512 (5.0%)	274 (2.5%)	—
1978	10,234	3,685 (36%)	2,716 (26%)	135 (1.3%)	649 (6.3%)	185 (1.8%)	—
1979	9,230	2,251 (24%)	1,811 (20%)	116 (1.3%)	531 (5.7%)	147 (1.6%)	146 (1.6%)
1980	10,991	2,280 (21%)	1,526 (14%)	45 (.4%)	410 (3.7%)	129 (1.2%)	180 (1.6%)
TOTALS	117,883	35,175 (30%)	25,604 (22%)	3,980 (3.4%)	8,457 (7.2%)	2,059 (1.8%)	2,172 (1.8%)

school systems, the elderly, drug and alcohol rehabilitation programs, the handicapped and impoverished areas. The unit is a modified bus which is staffed by ophthalmologists. It now screens 6,000 individuals annually and has screened a total of 150,000 to date. The number of positive findings and their breakdown is not available for this program. Their annual budget is \$50,000 per year and, therefore, the cost per screening is approximately \$8 per visit.

DISCUSSION

Since 1946 over 490,000 eye screenings have been performed by the Medical Society, Eyemobile Foundation and Commission for the Blind, with the Medical Society's "Eye Health Week" having performed the greatest number of screenings. However, the largest number of examinations performed annually has been by the Eyemobile Foundation and is most likely in part responsible for the diminishing attendance at the "Eye Health Week" screenings noted over the past several years.

It is interesting to note the difference between the total number of positive screenings and the number of glaucoma suspects discovered by the Medical Society (46% and 5.2%) and the Eyemobile Foundation (30% and 1.8%). The higher figures found for the Medical Society undoubtedly are reflected in part due to the difference in the ages of the populations of these two programs; the "Eye Health Week" is limited to persons thirty-five years of age and older, whereas the Eyemobile Foundation is not. Previous population studies using Schiottz tonometry have shown that 6 to 15 percent have an intraocular pressure greater than or equal to 21mm Hg,²⁰ which is the upper limit of normal used in the screenings. The Medical Society figure more closely approximate this figure and therefore probably examines a different population.

Because the populations that have been screened have not been random, the true prevalence of the disease cannot be

determined from these statistics. Still the percentage of glaucoma victims discerned by the Medical Society of New Jersey's "Eye Health Week" of 1.5 percent and the number of glaucoma suspects found by the Eyemobile Foundation of 1.8 percent falls within 0.36 percent and 2.0 percent, the range of prevalence rates quoted in the literature.¹¹ Therefore, one can say that the screening programs are indeed serving their purpose identifying those individuals with the disease and those for whom careful observation is warranted.

Of importance is the ratio of those patients discovered to have true glaucoma to those determined to be glaucoma suspects at the initial screening. According to the Medical Society, which has an excellent followup of all glaucoma suspects identified, one out of four suspects actually will prove to have glaucoma on more thorough examination. This figure compares well to the study of Hollows and Graham.¹³

SUMMARY

Formal eye screening programs have existed in New Jersey for over two decades. During this period over 490,000 individuals have been tested and 12,000 people have been identified as being glaucoma suspects on followup examination. Twenty-five percent of the identified glaucoma suspects or 1.5 percent of the total number screened will have glaucoma. This figure is in agreement with published studies and confirms the impression that the eye screening programs in New Jersey are effective in identifying glaucoma patients and those at risk for developing the disease.

REFERENCES

1. Louria DB, Lavenhar MA, Quinones MA, Schneider DJ, Foster JD: Program for risk factor modification and selective screening for ostensibly healthy adults. *J Med Soc NJ* 74:759-767, 1977.
2. Nozik, RA: Glaucoma screening—Good or evil. *Eye, Ear, Nose & Throat Monthly* 46:179-184, 1967.
3. McKeown T et al: *Screening in Medical Care*. New York, Oxford University Press, 1968.
4. Hart CR (ed.): *Screening in General Practice*. New York, Churchill Livingstone, 1975.
5. Cinotti AA, Siegel R: Eye health screening in New Jersey. *Sight Saving Review* 34:146-51, 1964.
6. Cinotti AA, Quinones MA: Eye health screening: A medical society's experience. *J Med Soc NJ* 69:873-78, 1972.
7. Cinotti AA, Quinones MA: Eye screening in New Jersey. *Sight Saving Review* 42:107-14, 1972.
8. Quinones MA, Cinotti AA: Multiphasic screening in Newark. *J Med Soc NJ* 72:31-33, 1975.
9. Schwartz B: Primary open-angle glaucoma, in Duane TD (ed): *Clinical Ophthalmology*. Hagerstown, MD, Harper and Row, chpt 52, p. 1, 1979.

"... the screening programs are indeed serving their purpose identifying those individuals with the disease and those for whom careful observation is warranted ..."

10. Armaly MF: Glaucoma annual review. *Arch Ophthalmol* 88:439-60, 1972.
11. Leske MC, *et al*: Epidemiologic aspects of open-angle glaucoma. *Am J Epidemiol* 109:250-70, 1979.
12. Graham PA: Epidemiology of simple glaucoma and ocular hypertension. *Br J Ophthalmol* 56:223-29, 1972.
13. Hollows EC *et al*: Intraocular pressure, glaucoma and glaucoma suspects in a defined population. *Br J Ophthalmol* 50:570-86, 1966.
14. Reynolds DC: Relative risk factors in chronic open-angle glaucoma: An epidemiologic study. *Am J Optom Physiol Optics* 54:116-20, 1977.
15. Perkins ES: Family studies in glaucoma. *Br J Ophthalmol* 58:529-35, 1974.
16. Duane TD *et al*: Glaucoma and ocular circulation theories of field loss. *Survey Ophthalmol* 15:364, 1971.
17. Emery JH *et al*: The lamina cribrosa in normal and glaucomatous human eyes. *Trans Am Acad Ophthalmol Otolaryn* 78:290-97, 1974.
18. *Glaucoma Detection and Treatment*. Proc. of the First National Glaucoma Conference, Tarpon Springs, Fl., January 1980. New York, National Society to Prevent Blindness, 1980.
19. *Glaucoma Alert Program*. New York, National Society to Prevent Blindness, Inc., 1977.
20. Graham PA *et al*: A critical review of methods of detecting glaucoma, in Hunt LB (ed): *Glaucoma: Epidemiology, Early Diagnosis and Some Aspects of Treatment*. Edinburgh & London, E and S Livingstone, 1966, pp. 103-15.

Unrecognized Bladder Diverticulum: A Cause of Persistent Urinary Tract Infection

DONALD J. KISSINGER, M.D., EDOUARD P. BEAUGARD, M.D.,
PHILIP S. AFFUSO, M.D., Teaneck*

A case is presented in which the cause of a persistent urinary tract infection occurring after a prostatectomy went undetected until a repeat urological evaluation revealed a massive bladder diverticulum.

Large bladder diverticula are uncommon, and therefore may not be diagnosed initially. Incomplete emptying may result in urinary stasis leading to infection. Infection after prostatectomy is common and, therefore, arouses little concern. However, when infection persists, a repeat urological evaluation is necessary. Herein we report a case of a massive bladder diverticulum which went undiagnosed for two years after a prostatectomy.

CASE REPORT

A 67-year-old male was hospitalized for evaluation of urinary frequency and urgency associated with recurrent urinary tract infections. Two years earlier the patient underwent a transurethral prostatectomy for benign prostatic hypertrophy. Since that time the patient had suffered with urinary tract infections, which had recurred despite numerous courses of various antibiotics. His residual urine was recorded between 300 and 350 cc on several different occasions. Treatment with bethanechol chloride caused the residual to drop to 200 cc. Repeat urological evaluation was not undertaken.

Rectal examination revealed the prostate to be flat and smooth. There was good rectal sphincter tone. Residual urine was 350 cc. Urinalysis revealed a full field of white blood cells. Urine culture revealed pseudomonas with a colony count greater than 100,000. Cystometry was normal. An intravenous pyelogram (I.V.P.) was normal (Figure 1). A

cystogram (Figure 2) revealed a massive bladder diverticulum located on the left superior aspect of the bladder. Cystoscopy revealed the diverticulum to originate on the left posterior wall, just superior to the left ureteral orifice which was deviated medially. Examination of the diverticulum with the cystoscope failed to reveal calculi or tumor within it. Remaining examination of the bladder was unremarkable. The prostatic fossa was free of obstruction. Bilateral retrograde pyelograms (Figure 3) revealed marked medial deviation of the left lower ureter. Diverticulectomy was performed. The postoperative course was unremarkable. Three months after surgery the residual urine was 50 cc. Urinalysis and urine culture were negative.

DISCUSSION

Most bladder diverticula are small, asymptomatic and require no treatment. Large ones may cause significant morbidity, resulting from urinary stasis. This ultimately leads to infection and to the possible formation of calculi. Large bladder diverticula often are overlooked because of their infrequent occurrence. The diagnosis is elusive unless the clinician looks for a bladder diverticulum. A cystogram is essential in determining the size and extent of the lesion.

*From the Department of Urology, Holy Name Hospital, Teaneck, where Drs. Kissinger, Beaugard and Affuso are members of the staff. Correspondence may be addressed to Dr. Affuso at the Hospital, Teaneck Rd., Teaneck, N.J. 07666.



Figure 1—Intravenous pyelogram was normal.



Figure 2—Cystogram reveals massive bladder diverticulum on the left superior aspect of the bladder.



Figure 3—Bilateral retrograde pyelograms reveal marked medial deviation of the left lower ureter.

CONCLUSION

Persistent urinary tract infection demands thorough evaluation of the urinary tract. This should include an intravenous pyelogram, cystoscopy, cystogram, cystometry and barium enema x-ray. Unless the uncommon causes of urinary tract infection are considered they will go undetected. Furthermore, the clinician never should hesitate to repeat examinations when the cause of the patient's problem remains unclear.

SUMMARY

Most bladder diverticula are small, asymptomatic and of little clinical significance. Large ones cause urinary stasis which leads to infection. Because of their infrequent occurrence large diverticula may go undetected.

A patient with persistent urinary tract infection after prostatectomy is described. The cause of this infection went undetected until a repeat urological evaluation was performed two years after the surgery. This case stresses the need for both thorough evaluation of all patients whose diagnosis is uncertain and the need to repeat studies when the cause of the problem remains unclear.

REFERENCES

1. Orandi A: Transurethral fulguration of bladder diverticulum. New procedure. *Urol* 10:30-32, 1977.
2. Vitale PJ, Woodside JR: Management of bladder diverticula by transurethral resection: Reevaluation of an old technique. *J Urol* 122:744-745, 1979.

The "Silent" Acute Abdomen of Schizophrenia*

JEFFREY T. APTER, M.D., Belle Mead*

Schizophrenic patients may not develop classical abdominal symptoms with an acute abdomen. This case report tells of a 24-year-old male, with acute appendicitis, who did not develop pain until late in the course. Instead he developed more severe psychiatric symptoms.

Schizophrenic patients appear to have an abnormally high threshold to painful stimuli.¹⁻⁴ The patient described below had acute appendicitis and did not present with typical symptoms until very late.

CASE HISTORY

A 24-year-old single male was admitted to the Carrier Clinic on April 27, 1980. The patient, a college graduate, had become increasingly withdrawn over a three-year period and began to exhibit bizarre behavior 12 months prior to admission. He became very regressed and developed many delusions, religious preoccupations, incapacitating rituals, and dysmorphopsia. The admitting diagnosis was schizophrenia and secondary depression as defined by Washington University Criteria.^{7,8} The patient was treated with trifluoperazine with improvement in psychotic symptoms but with no improvement in affective symptoms. Twelve electroconvulsive treatments resulted in noticeable improvement in affective symptoms, but delusions and religious rituals although considerably improved as compared with admission, continued. The last treatment was administered on July 16, 1980. On July 21 the patient became increasingly withdrawn, refused to get out of bed, became totally mute and appeared tense and fearful. The following day he refused all medications and did not eat. He appeared catatonic. On July 23 he said that his stomach hurt. An immediate blood count revealed 27,200 white blood cells; the patient was

transferred to the Medical Center at Princeton where an emergency appendectomy was performed. The surgeon found a perforated appendix which was localized. The patient made a good recovery.

DISCUSSION

Talbott and Linn described four primary findings: lack of verbalization of pain and discomfort; bodily self-mutilation; toleration and exhibition of loathsome lesions; and inability or unwillingness to tolerate medical care. They presented several cases in which the patients did not present with pain or classical symptoms of illness. They described a patient with myocardial infarction, self-castration and carcinoma.¹

Marchand described this phenomenon in the prephenothiazine era.⁶ Therefore, it cannot be attributed to drug effect. He found pain to be absent in 21.4 percent of patients with acute perforated peptic ulcer and in 36.8 percent with acute appendicitis.

This chronic schizophrenia patient did not verbalize symptoms of an acute abdominal condition such as nausea and pain until very late in the course of an acute appendicitis, probably not until after his appendix had ruptured. Instead he became increasingly withdrawn, fearful, mute and immobile.

*Dr. Apter is Associate in Psychiatry at the Carrier Foundation, Belle Mead and Instructor in Psychiatry, Rutgers Medical School, CMDNJ. He may be addressed at the Foundation, Belle Mead, New Jersey 08502.

This case report should alert all physicians dealing with schizophrenic patients to the need for vigilance for such problems. The sudden onset of muteness, severe withdrawal and other catatonic symptoms, coupled with severe anxiety in an otherwise recompensating patient should sensitize us to the "silent" acute abdomen as well as diverse other problems which may appear in schizophrenics. Although the basis of the problem is not clear, research on the relationship of endorphins to pain and to psychiatric illness might prove illuminating.

SUMMARY

Schizophrenic patients have an abnormally high pain threshold. Acute abdominal emergencies may, therefore, present without characteristic symptoms. A 24-year-old male schizophrenic developed acute appendicitis which did not present classically, until late in the course. Instead he developed catatonic-like symptoms. Physicians must be alert to the presentation. The sudden onset of severe withdrawal, muteness and other catatonic symptoms should warn the physician of the possibility of an acute abdomen. The lack of

pain perception in schizophrenic patients is unrelated to medication and was described in the pre-phenothiazine era.

REFERENCES

1. Talbott JA, Linn L: Reactions of schizophrenics to life-threatening disease. *Psychiatr Quart* 50:218-227, 1978.
2. Torrey E, Fuller J, van Kammen DP, Ballenger JC, Post RM, Sternberg DE, Cowdry RW: Headaches after lumbar puncture and insensitivity to pain in psychiatric patients. *N Engl J Med* 301:110-111, 1979.
3. Davis GC, Buchsbaum MS, van Kammen DP, Bunney WE Jr: Analgesia to pain stimuli in schizophrenics and its reversal by naltrexone. *Psychiatr Res* 1: 61-69, 1979.
4. Earl A, Earl EV: The blood pressure response to pain and emotion in schizophrenia. *J Nerv Ment Dis* 121:132-139, 1955.
5. Geschwind N: Letter to the Editor. Insensitivity to pain in psychotic patients. *N Engl J Med* 296:1480, 1977.
6. Marchand WE: Occurrence of painless acute surgical disorders in psychotic patients. *N Engl J Med* 253:51-55, 1955.
7. Feighner, JP, et al: Diagnostic criteria for use in psychiatric research. *Arch Gen Psychiatr* 26:57-63, 1972.
8. Guze SB, Woodruff RA, Clayton PJ: Secondary affective disorder: A study of 95 cases. *Psychol Med* 1:426-428, 1971.

Thrombosis of the Pampiniform Plexus*

DONALD ROTHMAN, M.D., Red Bank

Thrombosis of the pampiniform plexus has been reported, but it is uncommon. A recent case prompted this clinical description and demonstration of the gross specimen.

REPORT OF A CASE

A forty-four-year-old previously healthy man noted a tender irregular swelling in the right mid scrotum, several hours after playing baseball and tennis. He denied direct trauma and gastrointestinal distress, except mild anorexia. Examination revealed a one-centimeter irregular firm doubled mass in the spermatic cord which continued to the external ring as a five millimeter tubular structure separate from the vas. Persistence of the tender mass after four days prompted an inguinal-scrotal exploration. A single thrombosed vein doubled on itself extended from the internal ring to the testis (see figure). This was excised and ligated high. The thrombosis continued proximal to the internal ring, but it was felt unwarranted to extend the incision into the abdomen.

COMMENT

The pampiniform plexus of veins drains the testis, runs proximal in the cord and forms a single internal spermatic vein which joins the inferior vena cava retroperitoneally on the right side. On the left the internal spermatic vein joins the left renal vein; presumably due to valvular incompetence, anomalies such as varicoceles occur ninety-eight percent of the time on the left. Previously reported cases of pampiniform plexus thrombosis have indicated mostly left-sided involvement and do not describe the clot extending beyond the internal ring as in this case. It appears that some unsuspected or indirect trauma or increased pressure may have constricted and thrombosed this vein along its long course. Patients with this problem should be observed for coagulopathy or any pelvic visceral conditions that may contribute to this form of thrombosis.



Figure 1—Thrombus can be seen protruding from dilated spermatic vein.

REFERENCE

1. Anselme P: A case of spontaneous thrombosis of the pampiniform plexus of the testis. *Aust NZ J Surg* 47:801-802, 1977.

*From the Department of Surgery, Riverview Hospital, Red Bank, where Dr. Rothman is a member of the staff. He may be addressed at 565 State Highway #35, Red Bank, New Jersey 07701.

This information is compiled by the Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Arnold and Marie Schwartz College of Pharmacy and Health Sciences, Long Island University.*

1. Please comment on the drug interaction between cimetidine and benzodiazepines.

Cimetidine (sold as Tagamet®) is indicated for the short-term (up to eight weeks) treatment of duodenal ulcer, the treatment of pathological hypersecretory conditions, and prophylaxis of recurrent duodenal ulcer in patients likely to require surgical treatment for it.¹ As cimetidine inhibits microsomal enzyme metabolism, it has the potential to interact with other medications metabolized in the liver.²

Desmond and co-workers³ evaluated chlorthalidopoxide (sold as Librium®) disposition and elimination in eight normal subjects before and after one week of cimetidine therapy. The authors concluded that, at normal doses, cimetidine severely impairs the elimination of chlorthalidopoxide.

Klotz and Reimann² administered cimetidine and diazepam (sold as Valium®) to six volunteers. These workers demonstrated delayed diazepam clearance when cimetidine was administered. In addition, five of the six patients exhibited a much greater sedative effect than normally would be expected.

Patwardhan *et al.*⁴ studied the elimination of lorazepam (sold as Ativan®) and oxazepam (sold as Serax®) in eight normal volunteers previously treated for seven days with "therapeutic doses" of cimetidine. No impairment of lorazepam or oxazepam elimination was noted.

In conclusion, it appears that cimetidine may delay elimination and prolong the pharmacological effects of those benzodiazepines which are metabolized in the liver. As oxazepam and lorazepam are not metabolized in the liver and thus may not be affected by cimetidine, they may become benzodiazepines of choice in patients receiving concurrent cimetidine therapy.

REFERENCES

1. Anon.: *Physicians' Desk Reference*, 34th ed. Oradell, NJ, Medical Economics Company, 1980, p. 1636-1637.
2. Klotz U, Reimann I: Delayed clearance of diazepam due to cimetidine. *N Engl J Med* 302:1012-1014, (May 1) 1980.
3. Desmond PV, *et al.*: Cimetidine impairs elimination of chlorthalidopoxide (Librium®) in man. *Ann Intern Med* 93:266-268, 1980.
4. Patwardhan RV, *et al.*: Cimetidine spares the glucuronidation of lorazepam and oxazepam. *Gastroenterol* 79:912-916, 1980.

2. Please comment on the use of piroxicam in patients with arthritis.

Piroxicam is a new nonsteroidal anti-inflammatory agent

(NSAID) being investigated by Pfizer, under the trade name Feldene®. Piroxicam represents a new class of agents and has no structural similarity to the NSAIDs currently available in the USA.

Ginsberg¹ and coworkers administered piroxicam 20 mg once daily to 16 patients suffering from osteoarthritis or rheumatoid arthritis. Patients with osteoarthritis exhibited statistically significant improvement, but, although some patients with rheumatoid arthritis showed improvement, statistical significance was not reached.

Aderounmo *et al.*² administered piroxicam 20 mg daily to 34 patients with osteoarthritis. Piroxicam produced significant improvement in pain, swelling and general well-being throughout the 12-week study period. The authors concluded that piroxicam is effective for treatment of osteoarthritis.

Abruzzo, and co-workers³ treated 31 osteoarthritic patients with piroxicam or aspirin. These investigators found piroxicam to be significantly more effective than aspirin with fewer side effects.

Pisko *et al.*⁴ administered piroxicam 20 to 40 mg daily to 45 patients with rheumatoid arthritis for up to 946 days. Although 13 patients developed gastrointestinal ulcers (possibly due to the higher than recommended dose), the study concluded that it is an effective drug for treating rheumatoid arthritis.

Other investigations^{5,6} have shown piroxicam to compare favorably with other NSAIDs such as indomethacin and phenylbutazone (sold as Butazolidin®, Azolid® and others) for the treatment of osteoarthritis and rheumatoid arthritis.

Adverse effects occasionally noted with piroxicam therapy included dizziness, gastrointestinal irritation, peptic ulcer disease, dyspepsia, rash and headache. Drowsiness, tarry stools, flatulence and facial numbness also have been noted.⁷ The number and incidence of effects appear to compare favorably to those observed with agents currently available.¹⁻⁴

*The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm. D.; G. Chishti, M. Pharm., M.S.; H. L. Kirschenbaum, M.S., Pharm. D.

In conclusion, piroxicam is a new type of NSAID which appears to be as effective as the agents currently in practice. It has the advantage of a long half-life making once daily dosing possible.

REFERENCES

1. Ginsberg F, Appleboom T, Famaey JP: Efficacy and safety of piroxicam in the treatment of osteoarthritis and rheumatoid arthritis. *Curr Ther Res* 28:570-574, 1980.
2. Aderounmo FA, Walker O, Salako LA: Controlled trial of piroxicam in osteoarthritis in Africans. *Curr Ther Res* 28:888-893, 1980.
3. Abruzzo LJ, Sadeghian RM, Deltoratus JR, *et al*: *Clin Pharmacol Ther* 25:211, 1979.
4. Pisko JE, Rahman AM, Turner AR, *et al*: Long-term efficacy and safety of piroxicam in the treatment of rheumatoid arthritis: *Curr Ther Res* 28:852-859, 1980.
5. Box J, Box P, Turner R, *et al*: Piroxicam and rheumatoid arthritis: A double-blind 16-week study comparing piroxicam and phenylbutazone: *Roy Soc Med International Congress and Symposium Series* 1:41-46, 1978.
6. Steigerwald JC: Piroxicam and rheumatoid arthritis: A double-blind 16-week study comparing piroxicam and indomethacin: *Roy Soc Med International Congress and Symposium Series* 1:47-52, 1978.
7. Manahan LA, Dominquez C: Therapeutic answers to osteoarthritis: *Inpharma* 269:11 (Jan 10), 1981.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physicians Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

Selected Abstracts with Comments

Maloney M et al: Diagnosing hysterical conversion reactions in children. *J Pediatr* 97:1016, 1980.

Pediatricians must develop a facility for differentiating organic illness from hysterical conversion reactions which may include a wide assortment of sensory, motor, and visceral symptoms. Many physicians arrive at this diagnosis after exhaustive physical, radiographic and laboratory examinations are negative. This paper presents a biosocial profile of the "hysterical child" to assist in early, accurate, and effective diagnosis and management. The authors suggest obtaining a detailed psychosocial history in suspected cases. Emphasis should be placed on the following: 1) the level of functioning of parents and quality of family communication: In this study 85 percent of parents of hysterical patients were clinically depressed, 77 percent had family communication problems and 97 percent had recent family stress; 2) the personality of the child. Suspected patients may demonstrate a hysterical personality (i.e. dramatic, exhibitionistic, labile, excitable, egocentric, etc.) or may be high strung or fussy. Fifty-eight percent of the patients in this study had unresolved grief reactions. The classical "la belle indifference" may not be fully developed in children. In addition, the physical examination often disclosed contradictory and changing signs and symptoms.

Comment: In adolescent medicine the diagnosis of hysterical conversion reaction is a fairly frequent occurrence and must be differentiated from other psychosomatic illnesses such as malingering, psychophysiologic disorders, hypochondriasis, and somatopsychic disorders. It is imperative that we be familiar with these entities in order to avoid unrewarding and often expensive procedures, and to permit rapid diagnosis, so that early counseling can be initiated for treatment of the real "chief complaint"—the psychological conflict. (P. Stanford, M.D.)

Morley CJ et al: Dry artificial lung surfactant and its effect on very premature babies. *Lancet* 1:64, 1981

Artificial lung surfactant prepared with pure dipalmitoylphosphatidylcholine and phosphatidyl glycerol in the ratio of 7:3 was made as a dry powder and then blown down an endotracheal tube into the lungs of 22 very premature babies at birth. Only one dose was given. The treated babies did better than their 33 controls. Fewer needed ventilation, and those who did required lower pressure in the first six hours of life. None of the treated babies died, compared with eight of the controls.

Comment: We have reported on the use of artificial surfactant in *animal lungs*. Here again we are presenting the

first *human* experience of *dry artificial surfactant*. This British-made surfactant (University of Cambridge) differs from Japanese (Fujiwara's) in that it is dry, protein-free and more purified. Although the authors did not prevent RDS, it must be understood that only one dose was administered. Multiple doses might have improved the outcome. It is encouraging to see that things are progressing faster than expected. Now that the authors have set the standard and criteria for quality assessment and control of the artificial surfactant, we hope that there soon will be a better product and better techniques for application. (S. Sun, M.D.)

Vauthy PA et al: Acute upper airway obstruction in infants and children: Evaluation by the fiberoptic bronchoscope. *Ann Otol Rhinol Laryngol* 89:417, 1980

This paper describes the procedure for the evaluation of upper airways in children by fiberoptic bronchoscopy using a 3.2 mm and 5.3 mm Olympus fiberoptic bronchoscope. The procedure requires only topical anesthesia and can be performed in 20 seconds. Vauthy and Reddy report the instrumentation to be superior to oral airway examination in more than 800 studies over a four-year period, since it can be performed in an upright position and neither distorts airway anatomy nor exacerbates the obstruction. The instrumentation is performed easily and is well tolerated. They report it readily permits the differentiation of epiglottitis from subglottic croup and the diagnosis of foreign-body aspiration and other less common causes of airway obstruction. Additionally, the bronchoscopy may serve not only as a diagnostic tool but also as a therapeutic tool since intubation may proceed using the bronchoscope as a guide. The indications for instrumentation include history of apnea or aspiration, nasal obstruction, stridor, dysphagia, dysphonia, localized wheezing, localized airway turbulence, persistent atelectasis, lobar hyperaeration and suspected foreign body aspiration.

Comment: It is important to note that of the two bronchoscopes used, Vauthy and Reddy prefer the smaller instrument as a diagnostic tool. This is unfortunate as the 3.2 mm fiberoptic bronchoscope does *not* have a channel for

*Abstracted from the *Department of Pediatrics Newsletter, CMDNJ, New Jersey Medical School, Newark—Vol 3, No. 3 (March) 1981*. Selections are made by Richard H. Rapkin, M.D., Professor of Pediatrics and Medical Director of Children's Hospital, Newark, who is editor; Franklin C. Behrle, M.D., Professor and Chairman of Pediatrics; and Shyan C. Sun, M.D., Associate Professor of Pediatrics and Director, Department of Neonatology, Children's Hospital, Newark, who are coeditors. Comments are prepared by them and their associates.

suction or instrumentation. These types of channels would permit: 1) the oxygenation of the patient; 2) the suctioning of secretions which might be obstructing the visual field; and 3) the taking of adequate cultures from these secretions when necessary. This is an existing 3.5 mm fiberoptic bronchoscope which offers these options.

I heartily agree with studying patients with obstruction, dysphagia and dysphonia by bronchoscopy. I disagree strongly with the instrumentation of patients with persistent atelectasis, lobar hyperaeration and suspected foreign body, especially if the bronchoscope does not offer any therapeutic value. One should be wary of short communications proclaiming the magnificence of a new instrumental procedure in pediatric patients. Using bronchoscopy as a *routine diagnostic* procedure in children is frightening. The management of the case is far more important than the diagnosis.

Fiberoptic bronchoscopy is an excellent tool for the evaluation of *acute* upper airway obstruction. It also serves well the patient needing intubation for croup or epiglottitis since it avoids unnecessary use of heavy sedation or general anesthesia. Generally, I disagree that fiberoptic bronchoscopy should be used as a routine procedure for the evaluation of airway problems in the pediatric patient. The indications for this procedure are minimal. I would not care to see a push toward bronchoscopy every patient possible just because a new "safe" technical procedure is available. (M. Simpser, M.D.)

Finnell RH: Phenytoin®-induced teratogenesis: A mouse model. *Science* 211:483, 1981

In this article, the author reports a very carefully done study of teratogenesis due to Phenytoin® using a model of mice with genetically associated seizure disorders. They demonstrate a very high incidence of malformations and associated growth retardation in the fetus, the incidence of which is directly correlated with the serum Phenytoin® levels in the mother. Of particular note is that these levels are within the usual therapeutic range and are not in any way excessive. There is no correlation with active seizures during the gestation, nor is there any correlation with maternal or fetal genotype.

Comment: Certainly, there are always some reservations in generalizing from an animal model to human disorders. However, this study was able to reproduce malformations in the fetus very similar to those seen in the human disorders. Considering the numerous reports of fetal hydantoin syndrome and now the confirmation of a carefully controlled animal study, I would agree with the author's conclusion that this medication should be avoided whenever possible in women of reproductive age who are contemplating pregnancy. I hope that the author plans to go on to extend his model in the study of other common anticonvulsants and with particular attention to the time of greatest vulnerability during the gestation period. These additional studies would be helpful in the pragmatic concerns of managing patients with seizure disorders during their pregnancy. (L. Epstein, M.D.)

Faden AI et al: Opiate antagonist improves neurologic recovery after spinal injury. *Science* 211:493, 1981

The authors report that in an animal model the opiate antagonist naloxone significantly improves the hypotension which occurs within hours after cervical spinal injury. On double-blind neurologic evaluation, it appears that the ultimate neurologic recovery is better in the naloxone-treated group. They show fairly good documentation that an im-

provement in blood pressure during the first few hours after the injury could be obtained with the use of naloxone. Their speculation is that by limiting the hypotension and improving the blood flow to the spinal cord, the extent of the traumatic injury is limited, hence accounting for the better neurologic outcome.

Comment: If, in fact, it could be shown that endorphins are solely responsible for the hypotension following cervical injury, then naloxone would be the obvious best choice for therapy. It would have been interesting to have tried other agents used to treat hypotension in this experimental model. The only other minor criticism of the study is that it really looked only at the immediate post trauma situation of approximately three or four hours. While it may be true that the major damage to the cord might well occur during this interval, from a pragmatic point of view, patients are rarely under medical care in an ICU in that brief period of time. (L. Epstein, M.D.)

Nauseef WM et al: A study of the value of simple protective isolation in patients with granulocytopenia. *N Engl J Med* 304:448, 1981

Simple protective isolation ("reverse precautions": private room, gown, gloves and mask) was compared with standard hospital care in 43 granulocytopenic patients. No difference in infection incidence was noted, nor were there improvements in survival or response to antineoplastic therapy. "In the hospital without resources to provide maximal environmental protection, including ultra-clean air and the use of prophylactic oral non-absorbable antibiotics, standard care should suffice for the granulocytopenic patient, with emphasis on simple measures to prevent nosocomial infection—routine hand washing; . . . avoiding the use of urethral catheters and other invasive devices; changing all peripheral venous cannulas without fail every 48-72 hours, and providing optimal care of the skin and the oropharynx."

Comment: The authors also note that hospital food contains large numbers of gram-negative organisms and that "... the simple measure of allowing these patients to eat only well-cooked foods might provide considerable protection against endogenous infection caused by nosocomially acquired organisms."

Rubella Prevention. *Morbidity Mortality Weekly Rep (MMWR)* 30:37, 1981

More than 70 percent of persons with rubella are 15 years old or more. As many as 20 percent of these age groups are susceptible. Ninety-five percent of persons who receive live rubella vaccine after age 12 months will have long-term protection. Any *detectable rubella antibody* or *history of rubella vaccination* is presumptive evidence of immunity. The risk of teratogenicity of rubella vaccine is quite small (negligible). Rubella vaccination (inadvertently) during pregnancy is not a reason routinely to recommend termination. Increased emphasis needs to be placed on vaccinating females of child-bearing age. Educational and training institutions as well as health care facilities should strongly consider requiring proof of immunity for admission and employment. Routinely performing serology to determine immunity is expensive. "... Rubella vaccination of a woman who is not known to be pregnant and has no history of vaccination is justifiable without serologic testing."

Comment: A reminder to the primary care physicians: If you do not receive MMWR (free weekly from CDC, Atlanta, Ga.) I think you need to change jobs.

1981-1982

Committees and Councils

Standing Committees

Advisory to MSNJ Auxiliary (Staff Liaison, Shirley Walsh)

Frank R. Romano, M.D., <i>Chairman</i>	
(1982)	Dunellen
J. James Pegues, M.D., <i>Vice-Chairman</i>	
(1984)	Mount Holly
Julius Baber, M.D. (1984)	Bayonne
James E. Brennan, M.D. (1982)	Cherry Hill
Ralph J. Fioretti, M.D. (1983)	Rochelle Park
George T. Hare, M.D. (1983)	Pennsauken
Mrs. Elmer Grimes, <i>Auxiliary Member</i> (1982)	Haddonfield

Annual Meeting (Staff Liaison, Marion Walton)

Ralph J. Fioretti, M.D., <i>Chairman</i>	
(1984)	Rochelle Park
Francis X. Keeley, M.D., <i>Vice-Chairman</i>	
(1983)	Haddonfield
Joseph P. Cillo, M.D. (1982)	Cranford
Arthur C. Dietrick, M.D., (1984)	Mount Holly
Carl A. Restivo, Sr., M.D. (1982)	Jersey City
James H. Spillane, M.D., (1983)	Phillipsburg
Mrs. B. Ralph Wayman, Jr., <i>Auxiliary Member</i>	
(1982)	Yardley, Pa.
Arthur Bernstein, M.D. (Secretary)	
<i>Ex-officio</i>	South Orange
H. Irving Dunn, M.D., <i>Consultant</i>	Mantoloking
Andrew G. Hudacek, M.D., <i>Consultant</i>	Morristown
Charles S. Krueger, M.D., <i>Consultant</i>	Mount Holly

Scientific Program (Sections) (Staff Liaison, Marion Walton)

Allergy	
Clement A. Maccia, M.D., <i>Chairman</i>	Cranford
Walter M. Chemris, M.D., <i>Secretary</i>	Ridgewood

Anesthesiology	
Joseph A. Cipolla, M.D., <i>Chairman</i>	Scotch Plains
Stanley Bresticker, M.D., <i>Secretary</i>	New Brunswick

Cardiovascular Diseases	
Virender Sethi, M.D., <i>Chairman</i>	Hackensack
Pranay J. Vaidya, M.D., <i>Secretary</i>	New Milford

Chest Diseases	
Jack Wolfsdorf, M.D., <i>Chairman</i>	Camden
Samuel A. Cassell, M.D., <i>Secretary</i>	Paterson

Clinical Pathology	
John K. Ashton, M.D., <i>Chairman</i>	Plainfield
Harry M. Bowers, Jr., M.D., <i>Secretary</i>	Long Branch

Dermatology	
Ira H. Gouterman, M.D., <i>Chairman</i>	Newark
Adrian L. Connolly, M.D., <i>Secretary</i>	Orange

Emergency Medicine	
Rudolf E. Schwaebel, M.D., <i>Chairman</i>	Mendham
Richard M. Feldman, M.D., <i>Secretary</i>	Long Branch

Family Practice

David E. Sweet, M.D., <i>Chairman</i>	New Brunswick
William Pawluk, M.D., <i>Secretary</i>	Medford

Gastroenterology and Proctology

Dave B. Swerdlow, M.D., <i>Chairman</i>	Glen Ridge
Glen R. Mogan, M.D., <i>Secretary</i>	Livingston

Medicine

Michael Z. Lupovici, M.D., <i>Chairman</i>	Hightstown
Daniel P. McGovern, M.D., <i>Secretary</i>	Belle Mead

Neurosurgery and Neurology

Roger W. Countee, M.D., <i>Chairman</i>	Newark
Roger Duvoisin, M.D., <i>Secretary</i>	Piscataway

Nuclear Medicine

Steven D. Richman, M.D., <i>Chairman</i>	Morristown
Harry Agress, Jr., M.D., <i>Secretary</i>	Hackensack

Obstetrics and Gynecology

Daniel J. Colombi, M.D., <i>Chairman</i>	Cherry Hill
Robert L. Malatesta, M.D., <i>Secretary</i>	Plainfield

Oncology

Roderge J. Winn, M.D., <i>Chairman</i>	Millburn
Raymond F. Healey, M.D., <i>Secretary</i>	Montclair

Ophthalmology

Leo Masciulli, M.D., <i>Chairman</i>	East Brunswick
William J. Kustrup, M.D., <i>Secretary</i>	Trenton

Orthopedic Surgery

Joseph P. Pizzurro, M.D., <i>Chairman</i>	Ridgewood
Blackwell Sawyer, Jr., M.D., <i>Secretary</i>	Point Pleasant

Otolaryngology—Head and Neck Surgery

Alvin I. Glasgold, M.D., <i>Chairman</i>	New Brunswick
Secretary to be selected	

Pediatrics

Joseph C. Bogdan, M.D., <i>Chairman</i>	Neptune City
Secretary to be selected	

Physical Medicine and Rehabilitation

Otto Eisert, M.D., <i>Chairman</i>	Fair Lawn
Bernard Sandler, M.D., <i>Secretary</i>	Metuchen

Plastic and Reconstructive Surgery

Carl Quillen, M.D., <i>Chairman</i>	East Orange
Om P. Sawhney, M.D., <i>Secretary</i>	Plainfield

Psychiatry

George F. Wilson, M.D., <i>Chairman</i>	Belle Mead
Albert M. Bromberg, M.D., <i>Secretary</i>	Springfield

Radiology

Michael Och, M.D., <i>Chairman</i>	Newark
Patrick J. Conte, Jr., M.D., <i>Secretary</i>	Livingston

Rheumatism

Edwin S. Woolbert, M.D., <i>Chairman</i>	Pleasantville
Secretary to be selected	

Surgery	
Murray H. Seltzer, M.D., <i>Chairman</i>	Livingston
Christine E. Haycock, M.D., <i>Secretary</i>	Newark

Urology	
Thomas J. DeBenedictis, M.D., <i>Chairman</i>	Cherry Hill
Secretary to be selected	

Credentials
(Staff Liaison, Arthur White)

Arthur Bernstein, M.D., <i>Chairman</i> (Secretary), <i>Ex-Officio</i>	South Orange
Roger C. Laauwe, M.D., <i>Vice Chairman</i> (1983)	Wayne
William A. Allgair, M.D. (1982)	South River
Samuel C. Ingraham, II, M.D. (1984)	Ocean City
Thomas E. Mattingly, Jr., M.D. (1982)	Mount Holly
Marcel A. Mersch, M.D. (1983)	Hackettstown
Lawrence B. Owen, M.D. (1984)	Salem

Finance and Budget
(Staff Liaison, Arthur White)

Palma E. Formica, M.D., <i>Chairman</i> (1982)	New Brunswick
Frank Campo, M.D., <i>Vice-Chairman</i> (1983)	Trenton
Harry M. Carnes, M.D. (1984)	Audubon
Douglas M. Costabile, M.D. (1984)	Murray Hill
William Greifinger, M.D. (1982)	Belleville
Charles S. Krueger, M.D. (1983)	Mount Holly
Mrs. Ernest Redfield, <i>Auxiliary Member</i> (1982)	Woodbury
Rudolph C. Gering, M.D. (Treasurer), <i>Ex-Officio</i>	Pennington

Medical Defense and Insurance
(Staff Liaison, Joseph C. Lucci)

Michael J. Doyle, M.D., <i>Chairman</i> (1982)	Neptune
Frank J. Malta, M.D., <i>Vice-Chairman</i> (1983)	Toms River
Paul J. Hirsch, M.D. (1984)	Bridgewater
Stanley Karp, M.D. (1982)	Cinnaminson
E. Arthur Kratzman, M.D. (1984)	Plainfield
Harvey P. Yeager, M.D. (1983)	Millburn
Mrs. William Allgair, <i>Auxiliary Member</i> (1982)	South River
Arthur Bernstein, M.D. (Secretary), <i>Ex-Officio</i>	South Orange
John J. Crosby, Jr., M.D., <i>Consultant</i>	Jersey City
William J. D'Elia, M.D., <i>Consultant</i>	Spring Lake
John D. Franzoni, M.D., <i>Consultant</i>	Trenton
Ernest C. Hillman, Jr., M.D., <i>Consultant</i>	Glen Ridge
Paul J. Kreutz, M.D., <i>Consultant</i>	Elizabeth
Henry Liss, M.D., <i>Consultant</i>	Chatham
Daniel J. O'Regan, M.D., <i>Consultant</i>	Lawrenceville
Jesse Schulman, M.D., <i>Consultant</i>	Lakewood

Medical Education
(Staff Liaison, Martin E. Johnson)

Edwin W. Messey, M.D., <i>Chairman</i> (1984)	Willingboro
William Pomerantz, M.D. (1982) <i>Vice-Chairman</i>	Randolph
Alfred A. Alessi, M.D. (1983)	Hackensack
Robert W. Parvin, M.D. (1982)	Mount Holly
Roberta G. Rubin, M.D. (1983)	Montclair
Sidney Woltz, M.D. (1984)	Union City
Mrs. Richard DuPree, <i>Auxiliary Member</i> (1982)	Haddonfield
William C. Black, M.D., <i>Consultant</i>	Hackensack
S. Thomas Carter, Jr., M.D., <i>Consultant</i>	Voorhees
Alfonse A. Cinotti, M.D., <i>Consultant</i>	Jersey City
Joseph Ferrante, Jr., M.D., <i>Consultant</i>	Passaic
Paul J. Hirsch, M.D., <i>Consultant</i>	Bridgewater
Brewster S. Miller, M.D., <i>Consultant</i>	Somerville
William F. Minogue, M.D., <i>Consultant</i>	Summit
Ernest S. Redfield, M.D., <i>Consultant</i>	Woodbury
Robert S. Rigolosi, M.D., <i>Consultant</i>	Paramus
William S. Vaun, M.D., <i>Consultant</i>	Long Branch
Stephen F. Wang, M.D., <i>Consultant</i>	Morristown

Medical Student Loan Fund
(Staff Liaison, Arthur White)

Palma E. Formica, M.D., <i>Chairman</i> (1984)	New Brunswick
James P. Thompson, M.D., <i>Vice-Chairman</i> (1983)	Upper Montclair
Antonio P. Battaglia, M.D. (1982)	Gibbstown
George T. Hare, M.D. (1983)	Pennsauken
Pasquale A. Ruggieri, M.D. (1982)	Vineland
Mrs. Elliott C. Shull, Jr., <i>Auxiliary Member</i> (1982)	Cherry Hill

Publication
(Staff Liaison, Marjorie D. Treptow)

Paul J. Hirsch, M.D. (1982), <i>Chairman</i>	Bridgewater
Dirck L. Brendlinger, M.D. (1984)	Willingboro
Julio del Castillo, M.D. (1983)	Trenton
Mrs. Rodolfo Pascual, <i>Auxiliary Member</i> (1982)	Mount Holly
Howard D. Slobodien, M.D. (President-Elect) <i>Ex-Officio</i>	Perth Amboy
Arthur Bernstein, M.D. (Secretary) <i>Ex-Officio</i>	South Orange
Arthur Krosnick, M.D. (Editor), <i>Ex-Officio</i>	Trenton

Revision of Constitution and Bylaws
(Staff Liaison, Diana C. Gore)

Carl A. Restivo, Sr., M.D., <i>Chairman</i> (1984)	Jersey City
John H. Lifland, M.D. (1983)	Somerville
Daniel J. O'Regan, M.D. (1982)	Lawrenceville
Lawrence B. Owen, M.D. (1983)	Salem
Pascal A. Pironi, M.D. (1984)	Summit
Charles O. Tyler, M.D. (1982)	Camden
Mrs. James Brennan, <i>Auxiliary Member</i> (1982)	Cherry Hill
Arthur Bernstein, M.D. (Secretary), <i>Ex-Officio</i>	South Orange
Hillel M. Ben-Asher, M.D., <i>Consultant</i>	Morristown
William J. D'Elia, M.D., <i>Consultant</i>	Spring Lake
John S. Madara, M.D., <i>Consultant</i>	Salem
Henry J. Mineur, M.D., <i>Consultant</i>	Cranford
Charles I. Nadel, M.D., <i>Consultant</i>	Irvington
Carl A. Restivo, Jr., M.D. <i>Consultant</i>	Jersey City

Administrative Councils

Legislation
(Staff Liaison, June O'Hare)

Daniel J. O'Regan, M.D., <i>Chairman</i> (1983)	Lawrenceville
Irving P. Ratner, M.D., <i>Vice-Chairman</i> (1983)	Willingboro
Anthony P. Caggiano, Jr., M.D. (1983)	Glen Ridge
John J. Crosby, Jr., M.D. (1982)	Jersey City
William J. D'Elia, M.D. (1983)	Spring Lake
John D. Franzoni, M.D. (1982)	Trenton
Leon A. Fraser, M.D. (1982)	Trenton
Howard H. Lehr, M.D. (1984)	Fanwood
S. Stuart Mally, M.D. (1982)	Atlantic City
Robert F. Nunn, M.D. (1984)	Ocean City
Bernard A. Rineberg, M.D. (1984)	New Brunswick
Bernard Robins, M.D. (1984)	Springfield
<i>Auxiliary Member</i> to be selected	
Ernest S. Redfield, M.D. <i>Consultant</i>	Woodbury

Medical Services
(Staff Liaison, Joseph C. Lucci)

Victor H. Boogdanian, M.D., <i>Chairman</i> (1983)	New Brunswick
John S. Madara, M.D., <i>Vice-Chairman</i> (1983)	Salem

Joseph W. Fleisher, M.D. (1982) Bayonne
 Eugene H. Kain, M.D. (1982) Pennsauken
 Robert J. Lorello, M.D. (1984) Belleville
 John J. Pastore, M.D. (1984) Bridgeton
 Robert S. Rigolosi, M.D. (1982) Paramus
 William E. Ryan, M.D. (1982) Pennington
 Richard H. Sharrett, M.D. (1983) Plainfield
 Charles O. Tyler, M.D. (1983) Cherry Hill
 Edwin S. Wilson, M.D. (1984) Moorestown
 Frank A. Wolf, M.D. (1984) Phillipsburg
 Mrs. Frank R. Romano, *Auxiliary Member* (1982) Plainfield
 Howard D. Slobodien, M.D. (President-Elect),

Ex-Officio Perth Amboy
 Karl T. Franzoni, M.D., *Consultant* Trenton
 Frank M. Galioto, M.D., *Consultant* Bloomfield
 Joseph A. Lepree, M.D., *Consultant* Colts Neck
 Nicholas E. Marchione, M.D., *Consultant* Vineland
 Fred M. Palace, M.D., *Consultant* Mendham

Mental Health

(Staff Liaison, Joseph C. Lucci)

Harry H. Brunt, Jr., M.D. *Chairman*
 (1983) Neptune
 Farrell R. Crouse, M.D., *Vice-Chairman* (1982) Woodstown
 William H. Bristow, Jr., M.D. (1983) Ridgewood
 Joseph P. Cillo, M.D. (1984) Cranford
 Alvin Friedland, M.D. (1983) Livingston
 Raymond H. Gehl, M.D. (1982) West Orange
 Joseph J. Kline, M.D. (1984) Trenton
 Friedrich K. Racke, M.D. (1982) Mauricetown
 Gerald H. Rozan, M.D. (1983) Wayne
 Nancy S. Sibert, M.D. (1984) Woodbury
 G.L. Triebenbacher, M.D. (1982) Beach Haven
 B. Ralph Wayman, M.D. (1984) Morrisville, Pa.
 Mrs. Alexander D. Kovacs, *Auxiliary Member*
 (1982) Scotch Plains
 Augustus L. Baker, Jr., M.D. (Immediate
 Past-President), *Ex-Officio* Dover
 Thomas R. Houseknecht, M.D., *Consultant* Moorestown
 Arnold M. Kallen, M.D., *Consultant* Piscataway
 William R. Nadel, M.D., *Consultant* Summit
 Martin H. Weinberg, M.D., *Consultant* West Trenton

Public Health

(Staff Liaison, Joseph C. Lucci)

Edward M. Coe, M.D., *Chairman*
 (1983) Cranford
 Charles J. Moloney, M.D., *Vice-Chairman* (1984) Moorestown
 Thomas E. Desmond, M.D. (1982) Edison
 Mary DiMedio, M.D. (1984) Woodstown
 Albert Ehrlich, M.D. (1982) Fort Lee
 Enrico C. Funaro, M.D. (1982) Morristown
 Allen R. Griggs, D.O. (1983) River Edge
 Samuel C. Ingraham, II, M.D. (1984) Ocean City

Henry A. Katz, M.D. (1982) Parsippany
 Patrick J. McGovern, M.D. (1984) Jersey City
 William Pawluk, M.D. (1983) Medford
 Richard C. Reynolds, M.D. (1983) Piscataway
 Mrs. Guillermo Garcia, *Auxiliary Member* (1982) Bayonne
 Alexander D. Kovacs, M.D. (First Vice-President)

Ex-Officio Scotch Plains
 Ronald Altman, M.D., *Consultant* Trenton

Public Relations

(Staff Liaison, Martin E. Johnson)

Frank J. Malta, M.D., *Chairman*
 (1983) Toms River
 Andrew G. Hudacek, M.D., *Vice-Chairman*
 (1984) Morristown
 Joseph W. Bitsack, M.D. (1984) Hackensack
 Louis G. Bosco, M.D. (1984) Clifton
 Milton R. Bronstein, M.D. (1982) Edison
 Alexander D. Kovacs, M.D. (1982) Scotch Plains
 Robert J. Lorello, M.D. (1983) Belleville
 Edwin W. Messey, M.D. (1982) Willingboro

John J. Pastore, M.D. (1984) Vineland
 Victor M. Ruby, M.D. (1982) Atlantic City
 Jesse Schulman, M.D. (1983) Lakewood
 B. Ralph Wayman, Jr., M.D. (1983) Morrisville, Pa.
 Mrs. Frank Doggett, Jr. *Auxiliary Member* (1982) Atlantic City
 Frank Y. Watson, M.D. (Second Vice-President),
Ex-Officio Montclair
 Mark L. Engel, M.D., *Consultant* Holmdel

Special Committee to Council on Medical Services

Occupational Health, Workmen's Compensation and Rehabilitation

(Staff Liaison, Joseph C. Lucci)

Maurice E. Goldman, M.D., *Chairman* Linden
 Mathilda R. Vashak, M.D.,
Vice-Chairman North Plainfield
 George P. Bisgeier, M.D. Newark
 Andrew G. Hudacek, M.D. Morristown
 M. Noel Jennings, M.D. Holmdel
 Daniel J. O'Regan, M.D. Lawrenceville
 Edwin A. Turner, Jr., M.D. Upper Saddle River
 Ralph A. Young, M.D. Maplewood
 George A. Zazanis, M.D. Chatham
 Joseph A. Lepree, M.D., *Consultant* Colts Neck
 Eileen Measel, *Consultant* Trenton
 John S. Tobin, M.D., *Consultant* Wayne

Special Committees to Council on Public Health

Cancer Control

(Staff Liaison, Joseph C. Lucci)

Benjamin F. Rush, Jr., M.D., *Chairman* Newark
 Bernard J. Koven, M.D., *Vice-Chairman* Englewood
 Donald K. Brief, M.D. Millburn
 Sherman Garrison, M.D. Bridgeton
 Warren H. Knauer, M.D. Hillside
 Albert A. Pineda, M.D. Clifton
 Elissa J. Santoro, M.D. Irvington
 Eva B. Stahl, M.D. New Brunswick
 Harvey P. Yeager, M.D. Millburn

Child Health

(Staff Liaison, Joseph C. Lucci)

Glenn P. Lambert, M.D., *Chairman* Flemington
 James Q. Atkinson, M.D. Medford
 Anthony Brickman, M.D. Trenton
 William J. Farley, M.D. Brielle
 Douglas Ford, M.D. East Orange
 John J. LaMar, Jr., M.D. Salem

Conservation of Hearing and Speech

(Staff Liaison, Joseph C. Lucci)

Frank L. Kardos, M.D., *Chairman* Paterson
 Howard S. Farmer, M.D. Princeton
 Stephen Freifeld, M.D. Springfield
 Patrick Houston, M.D. Haddonfield
 Rowan C. Pearce, Jr., M.D. Haddonfield
 Lindsay L. Pratt, M.D. Camden
 Robert Stern, M.D. Mount Holly
 Raymond B. Strauss, M.D. Englewood
 Albert F. Moriconi, M.D., *Consultant* Trenton

Conservation of Vision
(Staff Liaison, Joseph C. Lucci)

Malcolm H. Bloch, M.D., <i>Chairman</i>	Morristown
Alfonse A. Cinotti, M.D.	Jersey City
Samuel Diskan, M.D.	Atlantic City
Harry T. Friebl, M.D.	Marlton
Oram R. Kline, M.D.	Camden
Ralph A. Skowron, M.D.	Cherry Hill
President and President-Elect, NJ Academy of Ophthalmology and Otolaryngology are <i>Consultants</i> :	
Malcolm H. Bloch, M.D.	Morristown
Frank Kardos, M.D.	Wayne

Environmental Health
(Staff Liaison, Joseph C. Lucci)

Philip J. G. Quigley, M.D., <i>Chairman</i>	Elizabeth
Seymour Charles, M.D.	Irvington
Stanley R. Lane, M.D.	Moorestown
Richard H. Musgnug, M.D.	Medford Lakes
E. Spencer Paisley, M.D.	Haddon Heights
Frank L. Rosen, M.D.	Maplewood
William I. Weiss, M.D.	Livingston
Meyer T. Weissman, M.D.	Elizabeth
Morris Joselow, Ph.D., <i>Consultant</i>	Newark

Special Committees

Drug and Alcohol Abuse (Ad Hoc Committee)
(Staff Liaison, Martin E. Johnson)

Richard J. Corbett, M.D., <i>Chairman</i>	Audubon
Jorge L. Bascara, M.D.	Trenton
Maria L. Bergamo, M.D.	Newark
Thomas R. Houseknecht, M.D.	Moorestown
Richard M. Liss, M.D.	Manville
Edwin A. Turner, Jr., M.D.	Upper Saddle River
B. Ralph Wayman, Jr., M.D.	Morrisville, Pa.
Daniel Greenfield, M.D., <i>Consultant</i>	Piscataway
Alfred E. Palmieri, M.D., <i>Consultant</i>	Clifton
Riley Regan, <i>Consultant</i>	Trenton
Richard J. Russo, <i>Consultant</i>	Trenton
Robert Warden, D.O., <i>Consultant</i>	Stratford

Emergency Medical Care
(Staff Liaison, Joseph C. Lucci)

Rudolf E. Schwaeble, M.D., <i>Chairman</i>	Mendham
R. Winfeld Betts, M.D., <i>Vice-Chairman</i>	Medford
Clifford B. Blasi, M.D.	Sea Girt
John A. Flood, Jr., M.D.	Trenton
Ronald L. Franz, M.D.	Morrisville, Pa.
Jack R. Karel, M.D.	Verona
Dorson S. Mills, M.D.	Elmer
Daniel J. O'Regan, M.D.	Lawrenceville
Michael D. Yablonski, M.D.	Hackensack
Joseph Kavanaugh, <i>Consultant</i>	Martinsville
Allen M. Koplin, M.D., <i>Consultant</i>	Trenton
Henry R. Liss, M.D., <i>Consultant</i>	Chatham
Louis Scibetta, <i>Consultant</i>	Princeton

Impaired Physicians
(Staff Liaison, Joseph C. Lucci)

Edward T. Carden, M.D., <i>Chairman</i>	Moorestown
Joyce M. Bailey, M.D.	Union
Lawrence F. Barnett, M.D.	Paterson
David I. Canavan, M.D.	Paterson
Edward M. Coe, M.D.	Cranford
Ronald I. Forster, M.D.	Union
Joseph Giannasio, M.D.	Jersey City
A. Starr Ingram, M.D.	Westfield
Boris G. Iovovich, M.D.	Fort Lee

Andrew J.C. Klein, M.D.	Orange
Thomas J. Liddy, M.D.	Livingston
Arthur McLellan, M.D.	Summit
Laurence R. Mundy, M.D.	Denville
Ward M. Schultz, M.D.	New Providence
Warren I. Brandwine, D.O., <i>Consultant</i>	Cherry Hill
Wilber F. Kell, D.O., <i>Consultant</i>	Somerdale
Anthony Komminos, M.D., <i>Consultant</i>	Morristown
Herbert McBride, M.D., <i>Consultant</i>	Piscataway
Henry B. Murphree, M.D., <i>Consultant</i>	Piscataway
Robert Warden, D.O., <i>Consultant</i>	Stratford

Long Range Planning and Development
(Staff Liaison, Diana C. Gore)

William J. D'Elia, M.D. (1983)	
<i>Chairman</i>	Spring Lake
Alfred A. Alessi, M.D. (1984)	Hackensack
H. Oliver Brown, M.D. (1982)	Westfield
Philip J. LoPresti, M.D. (1984)	Haddon Heights
Thomas E. Mattingly, Jr., M.D. (1982)	Mount Holly
Bernard Robins, M.D. (1983)	Springfield
Benjamin Wolfson, M.D. (1984)	Woodbury
L. Arne Skilbred, M.D., <i>Consultant</i>	Glen Ridge

Maternal and Child Care
(Staff Liaison, Joseph C. Lucci)

Peter A. Beaugard, M.D., <i>Chairman</i>	Rutherford
Peter L. De Lotto, Jr., M.D.	Denville
Miles E. Drake, M.D.	Vineland
Caterina A. Gregori, M.D.	Livingston
Gerard F. Hansen, M.D.	Hackensack
John T. Harrigan, M.D.	New Brunswick
Michael S. Kreitzer, M.D.	Westfield
Edwin W. Messey, M.D.	Willingboro
Thomas A. Noone, M.D.	Haddonfield
Nicholas J. Salerno, M.D.	Marlton
Thomas R.C. Sisson, M.D.	Perth Amboy
James P. Thompson, M.D.	Upper Montclair
Felix H. Vann, M.D.	Tenafly
Margaret Gregory, M.D., <i>Consultant</i>	Trenton
George J. Halpin, M.D., <i>Consultant</i>	Trenton

Medicaid
(Staff Liaison, Joseph C. Lucci)

(Words in parentheses indicate county and/or specialty represented)

Arganey L'A. Lucas, Jr., M.D., <i>Chairman</i> (Morris)	Morristown
Robert Abel, M.D. (Dermatology)	Elizabeth
James Q. Atkinson, M.D. (Burlington) (Family Physicians)	Medford
Thomas S. Bellavia, M.D. (Bergen)	Hasbrouck Heights
Bertram M. Bernstein, M.D. (Physical Medicine and Rehabilitation)	Trenton
Vidya B. Bhardwaj, M.D. (Anesthesiology)	West Orange
Charles Brandwein, M.D. (Gastroenterology)	East Brunswick
Bayard Coggeshall, M.D. (Morris)	Morristown
Tony Cohen, M.D. (Passaic)	Wayne
Miles E. Drake, M.D. (Cumberland)	Vineland
Eliot Freeman, M.D. (Radiology)	New Brunswick
Jonathan C. Gibbs, M.D. (Hudson)	Jersey City
Daniel Goldberg, M.D. (Ophthalmology and Otolaryngology)	Long Branch
Frank J. Malta, M.D. (Internal Medicine)	Toms River
Edmund Michael, M.D. (Union)	Plainfield
George J. Neumaier, M.D. (Middlesex) (Dermatology)	Edison
Bernard Pekala, M.D. (Camden) (Obstetrics and Gynecology)	Cherry Hill
Alan G. Posta, M.D. (Allergy)	Trenton
Carl J. Records, M.D. (Cape May)	Rio Grande
Harvey Shwed, M.D. (Essex)	Newark
William Silverman, M.D. (Atlantic)	Atlantic City
David Smith, M.D. (Orthopaedic)	Princeton
Murray Pine, D.O. (Osteopathic Physicians and Surgeons), <i>Consultant</i>	Newark
David Morris, M.D. (Gastrointestinal Endoscopy), <i>Consultant</i>	Greenbrook
James W. Parker, M.D., (Monmouth) <i>Consultant</i>	Red Bank

Medical Aspects of School Sports
(Staff Liaison, Joseph C. Lucci)

Christine E. Haycock, M.D., <i>Chairman</i>	Newark
Norman W. Garwood, M.D.	Crosswicks
Paul J. Hirsch, M.D.	Bridgewater
John C. Iacuzzo, M.D.	Somerville
Glenn P. Lambert, M.D.	Flemington
Allan M. Levy, M.D.	Westwood
Max M. Novich, M.D.	Perth Amboy
Benjamin I. Smolenski, M.D.	Cinnaminson
Andrew B. Weiss, M.D.	Newark
Sarah Dougherty, <i>Consultant</i>	Trenton
Abner West, <i>Consultant</i>	Elizabeth

Medicine and Religion
(Staff Liaison, Diana C. Gore)

John S. Madara, M.D., <i>Chairman</i>	Salem
Joseph F. Fennelly, M.D.	Madison
Rudolph C. Gering, M.D.	Pennington
Edmund E. Jacobitti, M.D.	Maywood
Louis McAfoos, M.D.	Cherry Hill

George A. Nitshe, M.D.	Monroeville
Edward W. Verner, M.D.	Newark
Russell L. McIntyre, Th.D., <i>Consultant</i>	Newark

Negotiations
(Staff Liaison, Joseph C. Lucci)

Alexander D. Kovacs, M.D. <i>Chairman</i>	Scotch Plains
Michael J. Doyle, M.D.	Neptune
Harold Kallman, M.D.	Edison
Myles C. Morrison, Jr., M.D.	Morristown
John J. Thompson, M.D.	Montclair
Joseph Woolwich, M.D.	Long Branch
George A. Zazanis, M.D.	Chatham

Retirement Plan for Physicians
(Staff Liaison, Joseph C. Lucci)

Nicholas E. Marchione, M.D. <i>Chairman</i>	Vineland
Paul J. Kreutz, M.D.	Elizabeth
Jack W. P. Love, M.D.	Woodbury
Albert F. Moriconi, M.D.	Trenton
Robert E. Steward, M.D.	New Brunswick

DOCTORS' NOTEBOOK

Trustees' Minutes July 19, 1981

A regular meeting of the Board of Trustees was held on Sunday, July 19, 1981 at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

House of Delegates' Attendance at Annual Meetings . . . Noted that of 395 elected delegates, 359 were registered and no more than 318 were present at any given session—only 271 at the final session.

. . . Directed that a report be made to the Board by the county medical societies of the actions taken in response to notice of a delegate's non-attendance at meetings of the House.

Membership . . . Noted the following membership statistics and observed that the number of exempt members relative to overall membership is a cause for concern:

Active Members		
Paid	7,400	
Exempt	850	8,250
Affiliate	82	
Associate	1	
Emeritus	667	750
Total Membership		9,000

Dues-Delinquent Members . . . Noted that 437 memberships were terminated on June 1, 1981 for nonpayment of dues; this is considerably less than last year. Since June 1, 180 have been reinstated.

Financial Statements . . . Received and approved the financial statements presented—the balance sheet as of May 31, 1981, the statement of revenue and expenses and analysis of expenses for 12 months ending May 31.

Osteopaths' Use of M.D. Designation . . . Noted that the court has ruled in favor of the State Board of Medical Examiners and declared that individuals are to be

licensed according to the degree by which they take the examination and are required to use that degree on all certificates, prescriptions, reports and so on.

Subordinated Loan . . . Noted that a memorandum recently has been mailed to members of the New Jersey Medical Inter-Insurance Exchange outlining the status of negotiations with the Internal Revenue Service on the deductibility of the subordinated loan debentures and reviewing the status of the position of the IRS. For strategic reasons the suit is being filed in the Tax Court rather than the Federal District Court. Arguments should be completed by December.

Medicare Reimbursement of Assisting Surgeon . . . Agreed to supply legal representation in the event settlement is not completed within a reasonable time in a case involving absolute discrimination against an assisting surgeon whose claims were denied by Medicare for a number of surgical procedures. An agreement with Medicare has been reached whereby prior claims are to be paid and future claims for specified procedures will be honored. Partial payment has been made. Status of the settlement will be updated at the next meeting of the Board.

Limiting Investigation of Physician . . . Agreed that MSNJ would join, as amicus curiae at no expense to the Society, a suit to limit investigation by the State of a case involving alleged claims of unlicensed personnel practicing medicine in a physician's office. Investigation so far revealed no documented evidence of the use of unlicensed personnel (one is a Cuban physician employed as a translator) and the Attorney General now plans to interview all or some of the patients seen by the physician in the last four to five years.

New Jersey State Medical Underwriters . . . Noted that a consulting actuary has recommended that the Public Advocate disapprove MIENJ's recent rate filing

with the Commissioner of Insurance; the Underwriter will oppose that report.

Medicaid Regulations . . .

(1) Directed that a communication be sent to the Commissioner of Human Services protesting the proposal of the Commissioner to amend NJAC 10:52-1.3 and 10:53-1.3 concerning same-day surgery for Medicaid patients, and that the matter be referred also to the Council on Medical Services, the Committee on Medicaid, the New Jersey Chapter of the American College of Surgeons, surgical subspecialties in New Jersey and the State Board of Medical Examiners for review and comment.

Note: The proposed regulation will require Medicaid recipients to undergo preadmission testing prior to elective surgery and also will govern reimbursement for out-of-state hospital outpatient departments who provide services to eligible NJ Medicaid recipients.

(2) Referred to the Committee on Medicaid for opinion a statement from the Department of Human Services indicating that certain surgical and diagnostic procedures are reimbursable under Medicaid only when written justification by the physician accompanies the claim form.

(3) Referred to the Committee on Medicaid for opinion a proposed regulation of the Division of Medical Assistance and Health Services requiring a second opinion by a board-certified specialist on certain elective surgical procedures.

Lifeline Program . . . Approved a recommendation that the Medical Society of New Jersey accept a one-year commitment to serve as statewide coordinator of the Lifeline Program—a pilot program funded by the Hunterdon Health Fund to assist shutins, the elderly and disabled individuals in need of emergency health services by means of a communication device for contacting the proper health personnel or facility.

Rule on Major Surgery . . . Noted that in response to insurance carriers' questioning the medical need for an assisting surgeon, the State Board of Medical Examiners has reiterated its position that any major surgery shall be performed only by a duly qualified surgeon with a duly qualified assisting physician or surgical resident in an approved training program, except in a matter of dire emergency.

CMDNJ . . . Received as informative a written report from the College of Medicine and Dentistry, and noted that tuition will be \$5,500 a semester next year, a ten percent increase.

. . . Agreed to support legislative efforts of CMDNJ to effect passage of a bill, which is endorsed by the Board of Higher Education, that would provide for greater flexibility in the day-to-day operation of the College and reserve to its Board of Trustees direct control over labor negotiations, purchasing, personnel, budget management, construction, and other matters, and notes the evolution of the College from an institution of disparate schools into a university of health sciences with a recommendation that the name be changed to the University of Medicine and Dentistry of New Jersey.

Annual Meeting—1982 . . . Agreed that the schedule for the 1982 annual meeting should conform to the format originally presented in the report of the Committee on Annual Meeting. The Reference Committee ("H") amendments to schedule reference committee meetings Saturday afternoon and Sunday and the scientific sessions on *Saturday and Sunday* were not feasible for the following reasons:

a. If reference committee meetings are held on Saturday afternoon and *Sunday*, there would not be sufficient time for delegates to review reference committee reports before consideration by the House on Monday morning.

b. If scientific sessions are scheduled for *Saturday and Sunday*, they would be in conflict with the House on Saturday and in conflict with reference committee meetings on Sunday.

c. The schedule is in conflict with Chapter II, Section 2 (c)—Sessions, of the Bylaws, which provides that: "The House of Delegates should meet on the first day of the annual meeting of this Society, but may meet in advance of, or after adjournment of, the annual meeting. Sessions may be adjourned from time to time, as may be necessary, but shall be so arranged

as not to conflict with the general sessions and section meetings."

. . . Instructed the Committee on Revision of Constitution and Bylaws to prepare an amendment to the Bylaws to permit greater flexibility in developing a format for the annual meeting. It was the opinion of the Board that the present Bylaws are too restrictive in that area.

. . . Referred the following suggestions to the Committee on Annual Meeting for consideration:

1. The possibility of the House meeting in two sessions on Saturday, such as from 9 to 10:30 a.m. and from 1 to 3 p.m., with reference committee meetings following each session.

2. If the House meets on Monday morning to consider reference committee reports, it can be presumed that component societies will schedule caucus meetings for early that morning, thus cutting into the attendance at the JEMPAC breakfast.

. . . Approved the following recommendations concerning the scientific sessions:

1. That each scientific session be limited to one guest speaker per session.

2. That the suggested time schedule for scientific sessions be approved and that the section officers be urged to combine as many sessions as possible.

3. That the Annual Meeting Committee's policies governing scientific sessions be approved.

. . . Approved a recommendation of the Annual Meeting Committee that scientific exhibits be solicited through the New Jersey medical schools as well as New Jersey hospitals.

. . . Voted to hold the reorganization meeting of the Board of Trustees on Monday evening, with dinner (to which spouses would be invited) following adjournment of the meeting.

Graduate Medical Education Program

. . . Noted that the Committee on Medical Education had not completed its evaluation of the Governor's 1982 budget appropriation for the State Graduate Medical Education Program, pending receipt of further information from the AMA and the AAFP and comments from the Graduate Medical Education Council of the Association for Hospital Medical Education of New Jersey and the Department of Higher Education.

Mandatory CME Requirements . . . Approved a recommendation that mandatory CME for membership in the Medical Society of New Jersey be sustained. Resolution #17 to discontinue mandatory CME requirements had been referred to the Committee on Medical Education, who felt there is no reasonable alternative to CME to satisfy either the public or physician community on the issue of accountability.

Student Financial Aid . . . Approved the following recommendation from the Committee on Medical Education:

That the Medical Society of New Jersey support the concept of loans to *medical and osteopathic* students which should be in the form of long-term loans, demonstrated need assistance, family involvement and deferred interest for three years after graduation. (Italics indicate Board amendment)

. . . Granted the request of the MSNJ Student Association to be permitted to present recommendations for alternative programs of funding at the next meeting of the Board so long as the information is supplied to the Board prior to the meeting.

Long Range Planning and Development: (1) Medical Students and Residents on Administrative Councils and Committees

. . . Approved a recommendation that the Board of Trustees accept inclusion of medical students for appointment to the Medical Society of New Jersey's administrative councils and committees.

. . . Approved a recommendation that the Board of Trustees agree to the addition of residents for appointment to the Medical Society of New Jersey's administrative councils and committees, provided the individual is a member of the Medical Society of New Jersey (through the component county society).

(2) Guidelines for House of Delegates . . . Approved the following proposed guidelines for consideration of annual meeting reports and resolutions:

(a) The House should consider reports from only the following:

Board of Trustees
Judicial Council
President
Secretary
Treasurer
Executive Director
Council on Legislation
Council on Medical Services
Council on Mental Health
Council on Public Health

Council on Public Relations
Committee on Annual Meeting
Committee on Finance and Budget
Committee on Long Range Planning and Development
Committee on Revision of Constitution and Bylaws

Reports from other standing councils and committees could be considered only when the House requests a report or the Board directs a council or committee to report to the House. Standing councils and committees in substantial disagreement with conclusions of the Board should file minority reports. Information reports of a given council or committee, if they contain important data, should be published in the MSNJ *Journal*.

(b) Resolutions which affirm existing policy established within the last five years should not be considered by the House. The Speaker would have the responsibility for determining whether a resolution merely reaffirms policy and rule accordingly. Resolutions which established policy more than five years ago should be reconsidered—reaffirmed, deleted or a new policy adopted. Staff should direct referrals to appropriate councils and committees for review and report to the Board.

(3) **Election of Officers and Referendum on Issues and Bylaws' Amendments** . . . Unanimously defeated a motion calling for a survey to determine whether the membership would favor electing the President-Elect, First and Second Vice-Presidents, Secretary, Treasurer, Board of Trustee members and Judicial Councilors through a mail ballot, and would consider a referendum vote on issues directed by the Board of Trustees or the House of Delegates and on amendments to the Bylaws.

The Long Range Planning Committee's review of the American Society of Association Executives' evaluation report on the structure of MSNJ, which recommended reevaluation of the opportunity of the membership to have a direct voice in the governing authority of the Society, had recommended that the Officers, Board members and Judicial Councilors be elected through a mail ballot mechanism and that the present procedure for selecting candidates to

positions on councils and committees be continued. A previous recommendation of the Long Range Planning Committee that a survey qualified to produce a defined result be conducted to determine whether the membership would be in favor of a mail ballot to elect officers, adopt major policy and amend the Bylaws was approved at the February 1st meeting of the Board of Trustees and a questionnaire and covering letter were to be prepared for approval of the Long Range Planning Committee. The defeat of the above-stated motion at this meeting of the Board (7/19/81) rescinds the Board's action of 2/1/81.

DRG Project Appeal Mechanism . . . Approved the following recommendation and suggested that the initial personnel consist of MSNJ members who are medical directors of PSROs and/or IPAs:

That the Medical Society of New Jersey form a (Council) Committee on Peer Review, and that the Department of Health and the New Jersey Hospital Association be advised that the Committee on Peer Review will provide statewide appeal and review services for the DRG program on a cost reimbursement basis.

Presently appeals from a hospital determination on DRG are directed to PSROs; the next level appeal on a statewide basis has not been established but the State Department of Health and the Hospital Association are both desirous of MSNJ providing this; representatives of medical and executive directors of New Jersey PSROs strongly encourage MSNJ to assume this role.

Temporary License for Unlicensed Residents in Approved Training Programs . . . Noted that on June 10, 1981 the State Board of Medical Examiners had voted to reaffirm is previous action not to issue temporary licenses to unlicensed residents in approved postgraduate training programs.

Limited Certification for X-ray Technicians . . . Voted to sustain its previous action to suspend legislative efforts to have introduced a bill that would broaden the scope of limited certification of x-ray technicians and to work out a procedure for granting limited licensure to x-ray technicians who perform limited x-ray work in physicians' offices under the direct supervision of

the physician. Individual physicians had urged the Board to renew these efforts, but the Radiological Society of New Jersey and the New Jersey Radiation Protection Commission still are opposed to any effort to create limited licensure of x-ray technicians.

Investigation of Pharmacies . . . Agreed not to consider participation in providing prescriptions in the investigation of certain retail pharmacies suspected of drug violations until a meeting can be arranged with the Attorney General's office and a written procedure adhered to.

Proposed Standards for Out-of-State Medical School Clinical Training . . . Referred to the Committee on Medical Education for study and report to the Board of Trustees (with a copy of the AMA Council on Medical Education report on Examinations for Medical Licensure) a proposed new rule from the State Board of Medical Examiners which would require any out-of-state medical school desiring to conduct clinical training programs within the State to secure prior approval of the State Board.

Interference with Therapy of a Treating Physician . . . Directed that there be reported to the Director of the Division of Youth and Family Services and the State Board of Medical Examiners a situation wherein personnel of the Division of Youth and Family Services interfered with the therapy ordered by a member of MSNJ for one of his patients.

Treating Patient with Controlled Dangerous Substances . . . Directed the staff to obtain a statement of interpretation of the law from the Division of Alcohol, Narcotics, and Drug Abuse Control concerning the treatment of a patient for addiction and the treatment of a patient for intractable pain via controlled substances and publish this information in the *Membership Newsletter*.

Note: The above was in response to a communication from the President of the Ocean County Medical Society commenting on a meeting that Society had with the Director of the Asbury Park Drug Treatment Center.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

This month, I wish to focus on a very exciting development for CMDNJ and for all who practice in the health professions in New Jersey. As this journal goes to press, we stand on the brink of the most important advancement for health sciences education in the State since the creation of CMDNJ in 1970.

I refer, of course, to the legislation currently under consideration in Trenton which would designate the College as a university and grant to it expanded powers and responsibilities for self-administration. The twin bills, S-3315 sponsored by Senator Matthew Feldman in the Senate and A-3525 sponsored by Speaker Christopher Jackman in the Assembly, have received the endorsement of the Board of Higher Education as well as excellent support in the executive branch and both houses of the Legislature. We hope to see them signed into law by the end of the year.

Although most of you probably are aware of this pending legislation, I think it is important that I review for you some of the reasons why we view the passage of these bills as a vital step in the College's development.

Granting CMDNJ university status, both in its impact upon the College and upon the health professions in the State, is a significant and important step for New Jersey. After two centuries of neglect, New Jersey is prepared to acknowledge the importance of medical and dental education and to accord to them the status they deserve in the public higher education system. In creating CMDNJ as a university, the State follows a model set by other states, and acknowledges the College's success and progress by putting it on equal footing with comparable and prestigious institutions across the country.

In its endorsement of the legislation, the New Jersey Board of Higher Education noted that "the name change is more properly reflective of the institution's unique mission as a statewide system of health care, education and research in medicine and dentistry." We feel that New Jersey, in charging the College with a broad-based mission that was unprecedented in health sciences education, intended to create an institution that far surpassed the definitions of

a "college." Through its continuous support through our first decade, the State has made it possible for CMDNJ to succeed in developing its unique role, and has thereby earned the prestige of a university of medicine and dentistry.

Of course, the new designation implies no change in the College's configuration or mission. CMDNJ does not expect to expand or alter its degree offerings. Such decisions are, and will remain, the province of the Board of Higher Education in its appropriate role of identifying needs and establishing priorities for programs in higher education throughout New Jersey.

The second element of the legislation is somewhat more complex, though of equal importance to the future of the College. The proposed statute will provide the new university with a far greater degree of operational flexibility. It will put the institution in a relationship to the State similar to that now enjoyed by Rutgers-The State University. Like Rutgers, the university of medicine and dentistry will be granted authority to manage its own budget; conduct its own labor relations; purchase for itself and manage its own construction.

This aspect of the legislation reflects a growing concern within the College that it must have a greater degree of operational flexibility if it is to continue its development and service to New Jersey in the years ahead. It is the consensus of the College's Board of Trustees and Administration that CMDNJ, after a decade of growth and progress, has outgrown the need for extraordinary scrutiny and close control by many State agencies which carried the institution through its difficult early years. The College's current governance structure which requires, in many instances, several layers of interaction with State agencies, now serves only to hamper the College's ability to act rapidly and directly on critical decisions.

In addition, since CMDNJ's needs are, by nature, highly specialized, the actions it requires often do not fit within the parameters and procedures established by various state agencies. The result is that CMDNJ projects often demand a level of special consideration which may be disruptive to the efficiency of these offices, and which may further lengthen the decision-making process.

This system has become both problematic and costly to the College. Lengthy delays in construction projects

and purchasing also have resulted in increasing overall costs. Grant monies and health care revenues have been lost as the College has been forced to delay or discontinue programs. Key faculty and administrative positions have remained vacant, despite their value to the College in developing superior educational programs and in increasing revenue-producing services, because of the difficulty in securing approval for competitive salary levels in specialties not covered by State guidelines.

To illustrate the difficulties we have encountered, let me focus on purchasing. As pointed out by our accrediting team from the Middle States Association, a centralized State purchasing process works well for the acquisition of standardized items purchased in relatively large numbers, but it is often inappropriate to the needs of a health sciences university. Many items purchased by CMDNJ are relatively unique, and seemingly equivalent items may have vast differences in performance and design.

As professionals, you can appreciate the difficulties which arise because the State's system does not allow for faculty preference in supplies and equipment for highly specialized research and for sophisticated patient care. Because of the sensitive nature of their work, physicians, obviously, are not willing to use less expensive substitute items they consider to be inferior.

Finally, as I noted in this column last month, CMDNJ may have to adjust, in the near future, to a greatly diminished level of public funding. In such a climate, CMDNJ has a heightened responsibility to make maximum use of its existing resources. With a greater degree of operational flexibility, the College will be able to plan more judiciously and more accurately for its needs, to capitalize on valuable opportunities more readily, and to adjust its internal priorities in accordance with New Jersey's emerging needs. By accepting this expanded responsibility for its own administration, CMDNJ will be able to make better use of the resources entrusted to it by New Jersey.

These are a few of the reasons why we consider the passage of this legislation so important. I hope that you and all of our colleagues share our enthusiasm for this major step forward for the health sciences education and service in New Jersey.

Recommendations of the Subcommittee on Nutrition of the Committee on Public Health of the New York Academy of Medicine*

The close relationship between the nutritional status of the patient and the outcome of serious disease is increasingly accepted by the health professions. Advances in the delivery of nutritional therapy to patients are reflected in the expanding number of hospitals with clinical nutrition teams. Nevertheless, progress in this field is very uneven in terms of systematic support.

In contrast to most other hospital operations with direct impact on the care of patients, the dietary department (or whatever other designation is used) usually has no direct and continuing accountability to the executive medical staff (i.e., the medical board), except, perhaps, for a periodic review of a diet manual necessitated by the requirement for formal Joint Commission on the Accreditation of Hospitals approval. Optimum treatment of ill patients makes it mandatory that the dietary department, dietitians, nurses, and physicians work closely together on a continuing basis so that food service is relevant to nutritional support. The expertise of the clinical dietitian must be utilized fully in a close partnership with physicians, nurses, and pharmacists as part of the clinical care team with adequate competence in providing adequate nutrition by the oral, enteral (tube), or parenteral routes.

To assure optimum opportunity for development of such a team effort, it is essential that formal responsibilities be assigned by the medical board of the hospital to assure that nutrition support enters into the daily care of patients.

RECOMMENDATIONS

The medical board, by virtue of its unique professional, organizational, and legal responsibility for clinical care, should include in its table of organization a Committee on Nutrition and Diet. Such a Committee on Nutrition and Diet should have broad participation, including individuals from the relevant

medical services and the dietary, nursing, pharmacy, and administrative departments. The Committee on Nutrition and Diet of the Medical Board should meet on a regular basis with the following responsibilities:

(1) Preparation and periodic review of the diet manual of the hospital which is to be revised as often as new information requires

(2) Development and supervision of a hospital-wide system for rapid initial assessment of nutritional status of patients, recommendations for adequate support, and periodic followup

(3) Assurance that food and nutrients offered meet nutritional requirements of the patient

(4) Evaluation of adequacies of methods used to provide nutrients in an effort to achieve as adequate an intake as possible regardless of the modality of feeding (i.e., oral, tube, or parenteral)

(5) Evaluation of newer technologies in nutritional therapeutic modalities for possible incorporation into hospital practice in relation to clinical effectiveness and cost

(6) Periodic reports to the medical board on the nutritional status of in- and outpatient populations based on surveys with adequate documentation

(7) Assurance of an adequate nutrition education program for medical attendings, housestaff, nurses, dietitians, and pharmacists.

(8) Establishment and monitoring of adequate professional standards for education, experience, and performance of the professional staff of the dietary department

(9) Participation of the Committee on Nutrition and Diet in the review process for the employment of candidates for the positions of director of food services and chief clinical dietitian

(10) Periodic review of personnel utilization and space requirements in the dietary department

(11) Because nutrition and food-related activities may be performed by more than one hospital department with the possibility of duplication of effort and diffusion of responsibility, the Committee on Nutrition and Diet should be designated as the coordinating group to avoid needless duplication and establish a clear chain of responsibility where indicated

(12) Responsibility for assuring the inclusion in the medical audit of pertinent criteria concerning nutritional care

Invitation To Join American Physicians Art Association

The American Physicians Art Association was organized in 1936 by the late Francis H. Redewill, Sr., M.D., a San Francisco urologist and talented marine painter. He and other artists held the first exhibition at the convention of the American Medical Association in San Francisco in 1936. Much national publicity has been accorded this group and it has been termed by critics as one of the finest nonprofessional art shows in the country. This year's exhibition will be held during the 75th annual Southern Medical Association meeting in New Orleans, Louisiana, November 15 to 18. The categories include oils and acrylics, water colors, sculpture, photography, arts and crafts, and/or graphics and miscellaneous. Membership is open to all physicians. Those interested should write to Milton S. Good, M.D., Treasurer, APAA, 610 Highlawn Avenue, Elizabethtown, PA 17022.

MSNJ
216th
Annual
Meeting

Atlantic City

May 14-17
1982

*This Statement on the Guidelines on the Establishment and Responsibilities of a Committee on Nutrition and Diet of a Hospital Medical Board, approved by the Committee on Public Health of The New York Academy of Medicine is reprinted from the *Bulletin of the New York Academy of Medicine* (second series) 57:400-402, (June) 1981.

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREbro-NICIN® capsule
contains:

Pentylenetetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.
AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY/IMMUNOLOGY—Leonard Cohen, M.D., 7545 York Drive, Clayton, MO 63105. New York University 1977. Also general internal medicine. Board certified (IM). Board eligible. Multi-specialty group, partnership, solo, academic. Available July 1982.

ANESTHESIOLOGY—Parvin Javadi, M.D., P.O. Box 50, Bradford, PA 16701. Pahlavi Medical School (Iran) 1964. Board eligible. Group, partnership, solo, academic. Available.

CARDIOLOGY—Lawrence J. Gessman, M.D., 21 Sabine Avenue, Narberth, PA 19072. University of Pennsylvania 1974. Board certified. Group, partnership (preferably with cardiac catheterization). Available.

G. R. Kolluru, M.D., 914 South Avenue, Apt. E-33, Secane, PA 19018. Andhra (India) 1973. Board certified (IM). Group, partnership, solo. Available.

Raj D. Savajiyani, M.D., 3807 North 30th Street, Apt. 25, Phoenix, AZ 85016. Baroda (India) 1975. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1982.

Anil Rastogi, M.D., 1350 West Bethune, Apt. 1502, Detroit, MI 48202. Rajasthan (India) 1974. Also, general internal medicine. Board certified (IM). Cardiac catheterization—group, partnership, solo. Available July 1982.

FAMILY MEDICINE—Allan P. Olivieri, M.D., 120 West 80th Street, New York, NY 10024. Cornell 1976. Board certified. Group, partnership, hospital affiliate (full time). Available.

Louis Verardo, M.D., 21 Walnut Road, Apt. 1—2A, Glen Cove, NY 11542. University of Bologna (Italy) 1978. Board eligible. Group (private or hospital-sponsored), preferably with opportunities for medical school/residency affiliation (for teaching purposes). Available.

K. J. Smith, M.D., P.O. Box 486, Durham, PA 18039. University of Washington 1976. Board eligible. Group. Available.

Catherine M. Sharkness, M.D., 6 Dartmouth Avenue, Apt. 2-A, Bridgewater, NJ 08807. Medical College of PA 1979. Board eligible. Group, partnership. Available August 1982.

GASTROENTEROLOGY—Yong Wun Chung, M.D., 3937 Lankenau Avenue, Philadelphia, PA 19131. Chonnam (Korea) 1972. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1982.

INTERNAL MEDICINE—Prabhakar N. Vaidya, M.D., 7752 Montgomery Road, Apt. 81, Cincinnati, OH 45236. Seth G.S. Medical College (India) 1969. Board certified. Single or multi-specialty group, partnership, or hospital-based. Available.

Lakhu Janimal Rohra, M.D., 86-19 Elmhurst Avenue, Apt. 3-E, Elmhurst, New York 11373. Baroda (India). Board eligible. Solo, associate, group. Available.

M. A. Menon, M.D., 355 Crale Boulevard, #202, Melvindale, MI 48122. Armed Forces Medical College (India) 1974. Subspecialty, gastroenterology. Board certified. Group, solo. Available.

Bankim D. Shah, M.D., 100 Hospital Plaza, #705, Paterson, NJ 07503. T.N. Medical (India) 1974. Group, partnership, solo. Available.

Rakesh Anand, M.D., 412 Maryland Avenue, Apt. 3-C, Staten Island, NY 10305. Medical Institute, New Delhi (India) 1973. Board certified. Solo, partnership, group. Available on one to two months' notice.

Marzie T. Nejad, M.D., 2200 Benjamin Franklin Parkway, Apt. S-1105, Philadelphia, PA 19130. Tehran University (Iran) 1969. Subspecialty, nephrology. Board eligible. Hospital-based, partnership, group. Available.

Kamal M. Bakri, M.D., 88 Slate Creek Drive, Apt. #3, Checktowaga, NY 14227. Baroda (India) 1973. Subspecialty, oncology. Board certified. Group, solo, or partnership. Available.

Peter E. Schottlander, M.D., 2408 Whittier Street, Rahway, NJ 07065. CMDNJ 1979. Board eligible. Partnership or group. Available July 1982.

Ruth C. Wang-Liang, M.D., 68 Colfax Road, Wayne, NJ 07470. Temple 1978. Board eligible. Group, HMO. Available.

Anthony A. Losardo, M.D., 1545 East 5th Street, Brooklyn, NY 11230. Einstein 1977. Subspecialty, cardiology. Board certified. Group or partnership. Available July 1982.

Alan Greenwald, M.D., 51-D Wedgewood Drive, Stratford, CT 06497. Chicago Medical 1976. Subspecialty, gastroenterology. Board certified. Board eligible (gastroenterology). Group, partnership, or multi-specialty group. Available July 1982.

Chaitanya S. Kadakia, M.D., Covered Bridge Terrace, Apt. D-2, Philippi, WV 26416. M.S. University (India) 1976. Board certified. Solo, associate, group. Available July 1982.

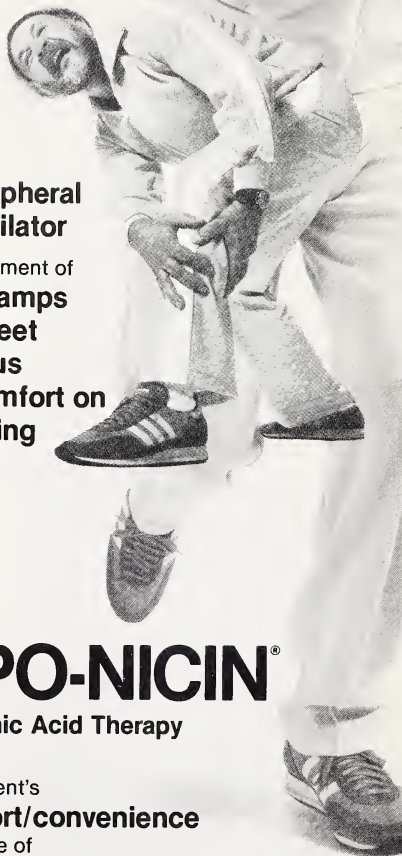
Neil H. Caplan, M.D., 27 West Penn Street, Long Beach, NY 11561. Bowman-Gray 1965. Board eligible. Outpatient (health service, clinic or other)—preferably in northern NJ. Available.

NUCLEAR MEDICINE—M. I. Straub, M.D., 254 Frances Street, Teaneck, NJ 07666. Semmelweis (Hungary). Special interest, diagnostic radiology. Board eligible. Available.

OBSTETRICS/GYNECOLOGY—F. Adibi, M.D., 84 Skyline Drive, Chalfont, PA 18914. Tehran (Iran) 1967. Board certified. Group/partnership. Available.

Dilipkumar G. Patel, M.D., 72 Duke Street, New Brunswick, NJ 08901. Baroda (India) 1974. Board eligible. Group, associate, solo, hospital. Available.

A peripheral vasodilator
for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing



LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	.....300 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	.....250 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	.....100 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Mohammed M. Mohiuddin, M.D., 215 Locksley Road, Syracuse, NY 13224. Osmania (India) 1973. Board eligible. Any type practice except academic position. Available.

Mridu B. Agarwal, M.D., 318 East 15th Street, Apt. 6-A, New York, NY 10003. Lady Hardinge (India) 1971. Solo, group, or partnership. Available.

Jung Fu Chen, M.D., P.O. Box 218, Petersburg, WV 26847. National Taiwan University 1956. Board eligible. Partnership, solo. Available.

Tsu Ming Chu, M.D., 269-19 80th Avenue, New Hyde Park, NY 11040. Kaohsiung Medical (Taiwan) 1972. Board eligible. Partnership, group, fellowship, full-time institute. Available.

OTOLARYNGOLOGY—Donald V. Wilson, M.D., 20 Lahiki Circle, Aiea, Hawaii 96701. Temple 1975. Board certified. Group, partnership, will consider solo. Available August 1982.

PATHOLOGY—Alexander J. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified (AP and CP). Any type practice including institutional. Available.

Aruna Kumar, M.D., 6223-B Newport Avenue, Norfolk, VA 23505. J.L.N. Medical (India) 1972. Board eligible (AP/CP). Group, solo, or partnership. Available.

PEDIATRICS—Fe C. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified. Any type practice. Available.

Yogesh J. Pandya, M.D., 24 Paerdeg—15th Street, Brooklyn, NY 11236. Baroda (India) 1973. Board eligible. Solo, group, partnership, hospital-based. Available.

Susheela Raghunathan, M.D., 9 Weston Place, East Brunswick, NJ 08816. India 1973. Board eligible. Group, institutional, clinic, emergency room, or house staff, student health center. Available.

Bernard Samtoy, M.D., 4040 Marshall Avenue, Lorain, OH 44053. Montpellier (France) 1974. Subspecialty, pediatric nephrology. Board certified. Group or partnership. Available October 1981.

PHYSIATRY—Lata Bhansali, M.D., 49 Hamilton Lane South, Plainsboro, NJ 08536. LTM Medical College (India) 1972. Board eligible. Group, clinic, or as staff. Available.

PSYCHIATRY—Paul L. Maitheny, M.D., 99 Pawnee Road, Lakewood, NJ 08701. University of Graz (Austria) 1951. Board eligible. Available.

PHYSIATRY—Lata Bhansali, M.D., 49 Hamilton Lane South, Plainsboro, NJ 08536. LTM Medical College (India) 1972. Board eligible. Group, clinic, or as staff. Available.

PULMONARY DISEASES—Paul M. Friedman, M.D., 1303 York Avenue, New York, NY 10021. SUNY-Downstate 1977. Board certified (IM). Group or partnership. Available July 1982.

Surinder K. Aneja, M.D., 90A Garden Village Drive, Apt. #4, Cheektowaga, NY 14227. Punjab (India) 1974. Also, general internal medicine. Board certified (IM). Group or solo. Available July 1982.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379. Shah (India) 1969. General practice and rehabilitation medicine. Available on three months' notice.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available.

Thomas A. Giangrasso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available.

SURGERY, GENERAL—S. R. Bajina, M.D., E1501, Park Towne Place, 2200 Benjamin Franklin Parkway, Philadelphia, PA 19130. Special interest—gastrointestinal endoscopy. Board certified. Solo, group, institutional-based. Available.

Rajendra M. Agarwal, M.D., 318 East 15th Street, New York, NY 10003. King George's (India) 1968. Solo, group, or partnership. Available.

P. Joshua Mammen, M.D., 404 West 51st Street, Apt. 2-B, New York, NY 10019. Trivandrum (India) 1970. Board eligible. Group, partnership, solo. Available.

B. Paulauskas, M.D., Route 1, Box 273-M, Lake Placid, FL 33852. Lithuania 1972. Special interest, vascular surgery. Board eligible. Group, partnership, solo. Available.

Kong Hua L. Go, M.D., 605 Louisiana Avenue, Apt. 17-A, Brooklyn, NY 11239. Far Eastern (Philippines) 1973. Board eligible. Any type practice. Available.

Job S. Kakkasseril, M.D., 3194 McGill Lane, Cincinnati, OH 45239. Pradesh (India) 1972. Board eligible. Group, solo, or partnership. Available.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available.

Indar J. Singh, M.D., WCMC #1C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available.

UROLOGY—Talluri Balaji, M.D., 1926 West Harrison St., Apt. 916, Chicago, IL 60612. Osmania (India) 1973. Solo. Available July 1982.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available.

Mahendra S. Shah, M.D., 62 Forsythia Lane, Paramus, NJ 07652. Baroda (India) 1968. Board certified. Group or partnership. Available.

Tahmoures Furoozy, M.D., 3646 Tuscula Avenue, Seaford, NY 11783. Esfahan University (Iran) 1966. Board eligible. Any type practice. Available.

Albert E. Kaufman, M.D., 2020 Forestdale Drive, Silver Spring, MD 20903. Ghent (Belgium) 1974. Board certified. Group, partnership. Available October 1981.

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

CARDIOLOGY

Oct.

- 1 **Coronary Artery Disease**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 14 **Mitral Valve Prolapse**
2 p.m.—John E. Runnells Hospital, Berkeley Heights
(*AMNJ*)
- 28 **Nuclear Cardiology**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- Sudden Cardiac Death**
30 8:30 a.m.-4:30 p.m.
- 31 9 a.m.-12:30 p.m.—Meadowlands Hilton, Secaucus
(*Deborah Heart and Lung Center and AMNJ*)

Nov.

- 4 **Mitral Valve Prolapse**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 4 **Cardiac Rehabilitation**
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 10 **Cardiac Rehabilitation**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(*Shore Memorial Hospital and AMNJ*)
- 16 **Cyanotic Congenital Heart Disease in Neonates**
12 noon-1 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)
- 18 **Type A Behavior in Coronary Heart Disease and Hypertension**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Oct.

- 1 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(*AMNJ*)
- 1 **Symposium for Emergency Physicians**
9 a.m.-5:30 p.m.

- 2 8:30 a.m.-4 p.m.—Bally's Park Place, Atlantic City
(*New Jersey ACEP and AMNJ*)
- 2 **Medical Grand Rounds**
11:30 a.m.—College Hospital, Newark
(*AMNJ*)
- 2 **Prophylactic Antibiotics**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 2 **Hypertension**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- Second Annual Consecutive Case Conference**
2 9 a.m.-2:30 p.m.
- 4 9 a.m.-12 noon—Playboy Resort, Great Gorge, McAfee
(*New Jersey Thoracic Society and AMNJ*)
- 6 **Hematology**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 6 **Adrenal Diseases**
8 p.m.—Burdette Tomlin Memorial Hospital, Cape May Court House
(*AMNJ*)
- 7 **Gouty Arthritis**
- 14 **Chronic Obstructive Pulmonary Disease**
- 21 **Update on Surgical Infections**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(*Columbus Hospital and AMNJ*)
- 7 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(*AMNJ*)
- 7 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section of AMNJ*)
- 7 **Antimicrobial Therapy in Childhood**
- 14 **Differential Diagnosis of Acute Arthritis**
- 21 **Current Problems in Occupational Medicine of Interest to Primary Care Physicians**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 7 **Urethral Syndrome**
- 14 **Non-Cardiac Pulmonary Edema**
- 21 **To be announced**
- 28 **Prostaglandins**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 7 **Endocrine Conferences**
14 3:30-5 p.m.—Rotates between Newark
- 21 Beth Israel Medical Center, College
- 28 Hospital, Newark and VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
- 9 **Symposium on Health and Obesity**
8 a.m.-5 p.m.—Rutgers Medical School, Piscataway
(*CMNDNJ*)

- 13 **Dermatology**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(*Shore Memorial Hospital and AMNJ*)
- 14 **Tropical Diseases Transmitted to the U.S.**
- 21 **Hypertension: Detection Followup**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 14 **Medical Problems of Aging**
9:30 a.m.-4:30 p.m.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center and AMNJ*)
- 16 **Antibiotics in the Immunosuppressed Patient**
11 a.m.-12 noon—Elizabeth General Hospital
(*Elizabeth General Hospital, Columbia University and AMNJ*)
- 16 **Diabetes/Insulin Pumps, Automated Pancreas**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 19 **Indications for Skin Biopsy**
12:30-1:30—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 19 **Nephrotic Syndrome**
12 noon-1 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)
- 20 **Pseudomembranous Enterocolitis**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 20 **Diabetes, Insulin and the Insulin Receptor**
1:30-5:30 p.m.—Drew University, Madison
(*Drew University, Ciba-Geigy Pharmaceutical Division and AMNJ*)
- 28 **Oral Complications of Chemotherapy**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 28 **The National Hypertension Program: Past, Present and Future Prospects**
3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(*Rutgers Medical School, Somerset County Heart Association and AMNJ*)
- 28 **Scientific Symposium: Diabetic Leg**
8 a.m.-1 p.m.—Rutgers Medical School, Piscataway
(*American Diabetes Association, NJ Affiliate and AMNJ*)
- Sudden Cardiac Death**
30 8:30 a.m.-4:30 p.m.
- 31 9 a.m.-12:30 p.m.—Meadowlands Hilton, Secaucus
(*Deborah Heart and Lung Center and AMNJ*)

Nov.

- 4 **New Treatments in Arthritis**
8:30 a.m.-3 p.m.—Rutgers Medical School, Piscataway
(*Arthritis Foundation, NJ Chapter, NJ Rheumatism Association and AMNJ*)

- 4 **Drug Addiction**
11:30 a.m.—Columbus Hospital,
Newark
(AMNJ)
 - 4 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East
Orange
(AMNJ)
 - 4 **Dinner Meeting**
6:30 p.m.—Holiday Inn, East Orange
(Endocrinology Section of AMNJ)
 - 4 **Captopril and Beta Blockers in Treatment
of Hypertension**
 - 11 **Calcium Antagonists**
3:30-5:30 p.m.—Middlesex General
Hospital, New Brunswick
(Rutgers Medical School, Somerset
County Heart Association and AMNJ)
 - 4 **Mitral Valve Prolapse**
 - 18 **Assessment of Thyroid Function**
9:30-11 a.m.—Bergen Pines County
Hospital, Paramus
(Bergen Pines County Hospital and
AMNJ)
 - 4 **Problems of Malnutrition and Obesity**
 - 11 **Nutrition and Resistance to Infection**
 - 18 **Type A Behavior in Coronary Heart
Disease and Hypertension**
 - 25 **Antibiotic Prophylaxis**
9-11 a.m.—Roosevelt Hospital, Menlo
Park
(Middlesex General Hospital and AMNJ)
 - 4 **Endocrine Conferences**
11 3:30-5 p.m.—Rotates between Newark
18 Beth Israel Medical Center, College
25 Hospital, Newark and VA Medical
Center, East Orange
(Endocrinology Section of AMNJ)
 - 5 **Sports Medicine/Trauma**
9 a.m.—Freehold Area Hospital
(AMNJ)
 - 5 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical
Center
(Endocrinology Section of AMNJ)
 - 6 **Medical Grand Rounds**
11:30 a.m.—College Hospital, Newark
(Endocrinology Section of AMNJ)
 - 6 **Workup of the Jaundiced Patient**
12 noon—St. Mary's Hospital, Orange
(AMNJ)
 - 6 **Gastrointestinal Bleeding**
12 noon—Freehold Area Hospital
(AMNJ)
 - 6 **Brain Trauma Management: A Quest for
Solutions**
9 a.m.—The Meadowlands Hilton,
Secaucus
(NJ Rehabilitation Hospital and AMNJ)
 - 10 **Diabetes**
11 a.m.—Greystone Park Psychiatric
Hospital
(AMNJ)
 - 11 **Hepatitis, Current Diagnosis and
Management in a Long-Term Care
Facility**
2 p.m.—John E. Runnells Hospital,
Berkeley Heights
(AMNJ)
 - 12 **Gerontology Meeting**
4-6 p.m.—Institute for Medical
Research, Copewood St., Camden
(Institute for Medical Research and
AMNJ)
 - 16 **Myasthenia Gravis**
12:30-1:30 p.m.—West Hudson
Hospital, Kearny
(West Hudson Hospital and AMNJ)
 - 16 **Cyanotic Congenital Heart Disease in
Neonate**
 - 30 **Varicella**
12 noon-1 p.m.—Mountainside
Hospital, Montclair
(Mountainside Hospital and AMNJ)
 - 17 **Drug-Induced Liver Disease**
12 noon—St. Mary's Hospital, Orange
(AMNJ)
 - 18 **Malignant Conditions of the Blood-
Forming Organs**
9 a.m.-4 p.m.—VA Medical Center, East
Orange
(VA Medical Center and AMNJ)
 - 18 **Transient Ischemic Attack**
11:30 a.m.-12:30 p.m.—Columbus
Hospital Newark
(Columbus Hospital and AMNJ)
 - 18 **Chemotherapy Update**
1-3 p.m.—Christ Hospital, Jersey City
(Christ Hospital and AMNJ)
 - 20 **Infectious Disease/Bacterial Endocarditis**
11 a.m.—Freehold Area Hospital
(AMNJ)
 - 24 **Endocrinology and Metabolism**
11 a.m.—Greystone Park Psychiatric
Hospital
(AMNJ)
 - 24 **The Spleen, Splenosis and Asplenic State**
8:30-10:30 a.m.—St. Joseph's Hospital,
Paterson
(St. Joseph's Hospital and AMNJ)
- NEUROLOGY/PSYCHIATRY**
- Oct.**
- 2 **Psychiatric Lecture Series**
9 1:30-5 p.m.—Trenton Psychiatric
16 Hospital
23 (Trenton Psychiatric Hospital
30 and AMNJ)
 - 5 **A Graduate Student with Masochistic
Fantasies**
8-10 p.m.—1046 So. Orange Ave., Short
Hills
(Essex Psychiatric Seminar and AMNJ)
 - 7 **Family Issues and Changing Roles**
 - 21 **A Behavioral Approach to Weight Control**
 - 28 **Paradoxical Therapy**
1-3 p.m.—Ancora Psychiatric Hospital,
Hammononton
(Ancora Psychiatric Hospital and AMNJ)
 - 7 **Child Psychiatry Case Conference**
14 8:30-10:30 a.m.—Trenton Psychiatric
21 Hospital
28 (Trenton Psychiatric Hospital and
AMNJ)
 - 8 **Medical Causes of Anxiety**
 - 22 **BCT in Medical Illness**
 - 29 **Foreign Medical Graduate Training**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(Carrier Foundation and AMNJ)
 - 13 **Psychopharmacology**
2 p.m.—Ancora Psychiatric Hospital,
Hammononton
(AMNJ)
 - 14 **What's New in Neurology-Evoked
Potentials**
8-10 p.m.—Bergen County Medical
Society
(NJ Medical Women's Association and
AMNJ)
 - 15 **Pediatric Developmental Diagnosis**
 - 22 3:30-7:45 p.m.—Carrier Foundation
Belle Mead
(Carrier Foundation and AMNJ)
 - 20 **The Violent Patient**
1:30-2:30 p.m.—Essex County Hospital
Center, Cedar Grove
(Essex County Hospital Center and
AMNJ)
 - 23 **Adolescent Emotional Disturbance:**
 - 24 **Therapy through Special Education
(Workshop)**
9:15 a.m.-4 p.m.—Carrier Foundation,
Belle Mead
(Carrier Foundation and AMNJ)
 - 24 **Prevention of Mental Illness in Children**
8:30 a.m.-4:30 p.m.—Mountainside
Hospital, Montclair
(Mountainside Hospital and AMNJ)
 - 28 **Medical Evaluation of the Dementias**
9-11 a.m.—Roosevelt Hospital, Menlo
Park
(Middlesex General Hospital and AMNJ)
 - 29 **Hypnosis in Medicine and Other Allied
Professions**
3:30-7:30 p.m.—Carrier Foundation,
Belle Mead
(Carrier Foundation and AMNJ)
- Nov.**
- 2 **Sleep Phobia in an 11-Year-Old Child**
8-10 p.m.—192 Chittenden Road,
Clifton
(Essex Psychiatric Seminar and AMNJ)
 - 3 **Psychiatric Case Conference**
 - 10 7:30-9:30 a.m.—Trenton Psychiatric
17 Hospital
24 (Trenton Psychiatric Hospital and
AMNJ)
 - 4 **Tardive Dyskinesia**
 - 18 **Drug Abuse**
1-3 p.m.—Ancora Psychiatric Hospital
Hammononton
(Ancora Hospital and AMNJ)
 - 4 **Child Psychiatry Case Conference**
 - 11 8:30-10:30 a.m.—Trenton Psychiatric
18 Hospital
25 (Trenton Psychiatric Hospital and
AMNJ)
 - 5 **Pediatric Developmental Diagnosis**
3:30-7:45 p.m.—Carrier Foundation,
Belle Mead
(Carrier Foundation and AMNJ)
 - 5 **Psychotropic Medications/Psychiatric
Complications of Non-psychiatric
Medications**
 - 19 **Panic Attacks: Cause and Effects**
12 noon-1 p.m.—Carrier Foundation,
Belle Mead
(Carrier Foundation and AMNJ)
 - 5 **Hypnosis in Medicine and Other Allied
Professions**
 - 12 3:30-7:30 p.m.—Carrier Foundation,
Belle Mead
(Carrier Foundation and AMNJ)
 - 6 **Psychiatric Lecture Series**
 - 13 1:30-5 p.m.—Trenton Psychiatric
20 Hospital
(Trenton Psychiatric Hospital and
AMNJ)
 - 10 **Psychopharmacology**
2 p.m.—Ancora Psychiatric Hospital,
Hammononton
(AMNJ)
 - 14 **The Psychological Aspects of Breast
Cancer**
1:30 p.m.—Holy Name Hospital,

SUDDEN CARDIAC DEATH

EXPERIMENTAL MODELS
& MECHANISMS

CLINICAL DIAGNOSTIC METHODS

ARRHYTHMIAS &
ELECTROPHYSIOLOGY

SURGICAL & MEDICAL
MANAGEMENT

OCT. 30, 31, '81

The Meadowlands Hilton

Secaucus, New Jersey
(15 minutes from New York City)

7th Biennial Symposium
Presented by



Deborah Heart and Lung Center

**A DISTINGUISHED FACULTY OF 20 CLINICIANS
AND RESEARCH SCIENTISTS INCLUDES:**

Joseph S. Alpert, M.D. • J. Thomas Bigger, Jr., M.D. •
Nabil El-Sherif, M.D. • Harry Goldberg, M.D. •
Alden H. Harken, M.D. • Leonard N. Horowitz, M.D. •
Thomas N. James, M.D. • Harold L. Kennedy, M.D. •
John K. Kjekshus, M.D. • Allan M. Lefer, Ph.D. •
Peter R. Maroko, M.D. • Barry J. Maron, M.D. •
Attilio Maseri, M.D. • Richard R. Miller, M.D. •
Michel Mirowski, M.D. • Onkar Singh Narula, M.D. •
Professor J. Frank Pantridge • Timothy J. Regan, M.D. •
Lair G.T. Ribeiro, M.D. • Richard L. Verrier, Ph.D.

This program is fully approved for continuing medical education credits, as listed in the printed program. For a copy of the program, please fill in the application below.

Clip & return to →

NJ

M. A. Ramsey, Coord.
Deborah Symposium
Box 369
Wayne, PA 19087

Please send me a copy of the Deborah Symposium program,
October 30-31, 1981.

NAME _____

Address/ Affil _____

City/ State _____

Zip Code _____

Ca²⁺ ENTRY BLOCKERS
ADENOSINE AND NEUROHUMORS:
 Advances in Coronary Vascular and Cardiac Control

RUTGERS UNIVERSITY
COLLEGE OF MEDICINE AND DENTISTRY
 OF NEW JERSEY
 RUTGERS MEDICAL SCHOOL
 INSTITUTE FOR PRECLINICAL
 PHARMACOLOGY
 MILES LABORATORIES, INC.

October 29 - 30, 1981
 CMDNJ - Rutgers Medical School
 Piscataway, New Jersey

OVERVIEW: The calcium entry blockers are proving to be an important class of compounds in elucidating the cellular etiology of cardiovascular diseases such as arrhythmias, angina, infarct, hypertension and cardiac hypertrophy. Although there is good evidence to suggest important extra-cardiovascular effects, this symposium will focus on the electrophysiological and mechanical actions of these drugs on cardiac and vascular muscle.

SESSIONS: Ca²⁺ Entry Blockers: Cardiac Effects • Ca²⁺ Entry Blockers: Vascular Effects • Adenosine and Ca²⁺ Entry Blockers • Adenosine and Neurohumors

FACULTY: Distinguished group of national and international scientific investigators.

For a Comprehensive Program Contact: Pat Reid, CMDNJ - Office of Continuing Education, Box 101 - University Heights, Piscataway, New Jersey 08854 (201) 463-4707.

Academy of Medicine of New Jersey
Newark Beth Israel Medical Center

Present A Symposium On

SURGICAL MANPOWER, REGIONALIZATION AND SECOND OPINION

On
Saturday, October 31, 1981
8:00 A.M.-1:00 P.M.

at
Newark Beth Israel Medical Center

The program will include presentations by nationally prominent and local speakers on rates of surgery in the United States, surgical manpower (past, present & future), physician manpower in New Jersey, the question of whether surgical services should be regionalized, current status of surgical second opinion programs, and utilization of surgical second opinion programs in New Jersey. The program is designed for all surgeons and surgical sub-specialties.

For further information, please contact:

Executive Offices
 Academy of Medicine of New Jersey
 Two Princess Road
 Lawrenceville, NJ 08648
 Phone: (609) 896-1717



COLUMBIA UNIVERSITY, COLLEGE OF PHYSICIANS & SURGEONS announces the following postgraduate medicine courses. Each course has been approved for the designated number of credit hours in Category 1, A.M.A.'s P.R.A. Contact: Dr. Elizabeth C. Gerst, Director, Continuing Education Director, 630 West 168th Street, New York, N.Y. 10032; telephone (212) 694-3682.

Ocular Inflammation, Diagnosis and Therapeutics, September 24 & 25, 1981 (Thursday & Friday). Fee: \$220; Resident's Fee: \$110 (ESHEI Alumni: \$110). 14 Credit Hours. Directors: Albert J. Hofeldt, M.D. and Laszlo Z. Bito, Ph.D.

Advances in Surgical Pathology (5th Annual Course), October 12-14, 1981 (Monday-Wednesday). Fee: \$300 (or \$125/day); Resident's Fee: \$150 (or \$60/day), includes syllabus and luncheons. 21 Credit Hours. Directors: Cecilia Fenoglio, M.D. and Luciano Ozzello, M.D.

Immunodiagnosis of Allergic, Rheumatic and Infectious Diseases, October 15 & 16, 1981 (Thursday & Friday) at the New York Academy of Medicine. Fee: \$200; Resident's Fee: \$100, includes syllabus and luncheons. 15 Credit Hours. Directors: Michael H. Grieco, M.D. and Stanley R. Fine, M.D.

Renal Biopsy in Medical Diseases of the Kidney, October 19-23, 1981 (Monday-Friday). Fee: \$495; Resident's Fee: \$245, includes syllabus, Kodachrome slides, electronmicrographs of "classic" renal lesions, luncheons and continental breakfasts. Director: Conrad Pirani, M.D.

21st Annual Review Course in Obstetrics and Gynecology, October 26-30, 1981 (Monday-Friday). Fee: \$450; Resident's Fee: \$225, includes syllabus and luncheons. 35 Credit Hours; 35 Cognates (A.C.O.G.); 35 Elective Hours (A.A.F.P.). Director: Raymond L. Vande Wiele, M.D.

Workshop on Thyroid Disease; 6th Annual Workshop of the American Thyroid Association, November 5 & 6, 1981 (Thursday & Friday) at the New York Academy of Medicine. Fee: \$250, includes syllabus, luncheons and reception. 16

Credit Hours; (A.A.F.P. credits pending). Directors: C.R. Feind and members of the A.T.A. Education Committee.

Recent Advances in Dementia, November 19 & 20, 1981 (Thursday & Friday). Fee: \$220; Resident's Fee: \$110; Ph.D.'s Fee: \$125. 14 Credit Hours. Directors: Richard Mayeux, M.D. and Wilma Rosen, Ph.D.

Principles and Techniques for the Use of External Fixation, November 21, 1981 (Saturday). Fee: \$100, includes course-related materials, workshop specimens, and luncheon, 8.5 Credit Hours. Director: S. Ashby Grantham, M.D.

Symposium on Nutrition and Drugs, December 3 & 4, 1981 (Wednesday & Thursday) at the New York Statler Hotel. Fee: \$98, includes luncheon. 11 Credit Hours; 11 Elective Hours (A.A.F.P.); 11 Hours (American Dietetic Association). Director: Myron Winick, M.D.

Continuing Education Program for Ophthalmologists, 1981-1982, Five Saturdays: (A) Dec 5, 1981: **Intraocular lenses**; (B) Jan 9, 1982: **Lids and Lacrimal Glands**; (C) Feb 6, 1982: **Lasers in Ophthalmology**; (D) March 6, 1982: **Instruments in Ocular Surgery**; (E) April 3, 1982: **Strabismus**. Fee: \$100/session; Resident's Fee: \$30/session, includes luncheons. 7 Credit Hours each Session. Director: R. Linsy Farris, M.D.

Postgraduate Review Course in Urological Pathology and Diagnostic Radiology, January 13-17, 1982 (Wednesday-Sunday). Fee: \$450, includes continental breakfasts, luncheons and pathology and radiology Kodachrome slides. 40 Credit Hours. Director: Myron Tannenbaum, M.D., Ph.D.

- Teaneck,
(*American Cancer Society, Bergen County, Holy Name Hospital and AMNJ*)
- 19 Musculo-Skeletal System—Exercise Physiology**
4-6 p.m.—Institute for Medical Research
Copewood St., Camden
(*Institute for Medical Research and AMNJ*)

OBSTETRICS/GYNECOLOGY

Nov.

- 14 Update on the Care of the Female Patient for Primary Physicians**
9 a.m.-5 p.m.—Stevens Institute of Technology, Hoboken
(*Hudson County Medical Society and AMNJ*)
- 24 The Exercising Female—Physiological and Pathological Aspects—Pregnant and Non-Pregnant Women**
12 noon—Freehold Area Hospital
(*AMNJ*)

PATHOLOGY

Oct.

- 6 Hematology**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)

Nov.

- 14 The Influence of Pathologic Factors in Breast Cancer Management**
9 a.m.—Holy Name Hospital, Teaneck
(*American Cancer Society, Bergen County, Holy Name Hospital and AMNJ*)
- 25 Clinical Pathology Conference**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)

PEDIATRICS

Oct.

- 1 Rheumatoid Arthritis in Children**
10:30 a.m.—Freehold Area Hospital
(*AMNJ*)
- 7 Antimicrobial Therapy in Childhood**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 15 Pediatric Developmental Diagnosis**
22 3:30-7:45 p.m.—Carrier Foundation,
29 Belle Mead
(*Carrier Foundation and AMNJ*)
- 23- Adolescent Emotional Disturbance:**
24 **Therapy Through Special Education (Workshop)**
9:15 a.m.-4 p.m.—Carrier Foundation,
Belle Mead
(*Carrier Foundation and AMNJ*)

- 24 Prevention of Mental Illness in Children**
8:30 a.m.-4:30 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)
- 27 Breast Feeding and Its Role in Host Defense**
8:30-10:30 a.m.—St. Joseph's Hospital,
Paterson
(*St. Joseph's Hospital and AMNJ*)

Nov.

- 5 Pediatric Developmental Diagnosis**
3:30-7:45 p.m.—Carrier Foundation,
Belle Mead
(*Carrier Foundation and AMNJ*)
- 24 The Spleen, Splenosis and Asplenic State**
8:30-10:30 a.m.—St. Joseph's Hospital,
Paterson
(*St. Joseph's Hospital and AMNJ*)

RADIOLOGY

Oct.

- 1 Radiology of the Skull and Cervical Spine**
10 a.m.—Bally's Park Place, Atlantic City
(*New Jersey ACEP and AMNJ*)
- 24 Advanced Echocardiography**
25 9 a.m.-5 p.m.—Nassau Inn, Princeton
(*The National Foundation for Non-Invasive Diagnostics and AMNJ*)
- 28 Nuclear Cardiology**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)

Nov.

- 7 Real-Time, Cross-Sectional Sector Scanning**
9 a.m.-5 p.m.—Nassau Inn, Princeton
(*The National Foundation for Non-Invasive Diagnostics and AMNJ*)
- 14 Radiography and Ultrasonography in Early Diagnosis of Breast Cancer**
9:30 a.m.—Holy Name Hospital,
Teaneck
(*American Cancer Society, Bergen County, Holy Name Hospital and AMNJ*)
- 14 Radiation Therapy as Primary Modality in Breast Cancer**
3 p.m.—Holy Name Hospital, Teaneck
(*American Cancer Society, Bergen County, Holy Name Hospital and AMNJ*)

GENERAL SURGERY

Oct.

- 7 Surgical Nutrition**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 8 Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital,
Kearny
(*West Hudson Hospital and AMNJ*)
- 30 Controversies in Cancer Management**

- 31** 12 noon-3:30 p.m.—Hilton Inn, Tinton Falls
(*Jersey Shore Medical Center*)
- 31 Surgical Manpower, Regionalization and Second Opinion**
8 a.m.-1 p.m.—Newark Beth Israel Medical Center
(*AMNJ*)

Nov.

- 12 Tumor Conference**
12 noon-1 p.m.—West Hudson Hospital,
Kearny
(*West Hudson Hospital and AMNJ*)
- 14 Breast Cancer-1981**
8:30 a.m.-4:30 p.m.—Holy Name Hospital, Teaneck
(*American Cancer Society, Bergen County, Holy Name Hospital and AMNJ*)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

Oct.

- 14 Annual Scientific Meeting—Ophthalmology Program**
8:30 a.m.-5 p.m.—Nassau Inn, Princeton
(*New Jersey Academy of Ophthalmology and Otolaryngology and AMNJ*)
- 14 Annual Scientific Meeting—Otolaryngology Program**
8:30 a.m.-5 p.m.—Nassau Inn, Princeton
(*New Jersey Academy of Ophthalmology and Otolaryngology and AMNJ*)

MISCELLANEOUS

Oct.

- 1 Aging in Plants**
8 Aging in Ciliates
15 Aging in Invertebrates I
22 Aging in Invertebrates II
29 Physiology of Aging in Mammals
4-6 p.m.—Institute for Medical Research
Copewood St., Camden
(*Institute for Medical Research and AMNJ*)
- 20 Malpractice**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 21 Malpractice**
1:30 p.m.—Trenton Psychiatric Hospital
(*AMNJ*)

Nov.

- 11 The Patient's Bill of Rights and Physician Conduct in Hospital**
1 p.m.—Christ Hospital, Jersey City
(*AMNJ*)
- 24 Malpractice**
8 p.m.—Warren Hospital, Phillipsburg
(*AMNJ*)

Additional CME Opportunities See Pages 633, 708

Dr. Howard J. Alfandre

At the untimely age of 47, Howard J. Alfandre, M.D., a member of our Union County component, died of leukemia on July 8. Born in Brooklyn, Dr. Alfandre earned his medical degree at New York Medical College, class of 1961, and following duty with the U.S. Navy, pursued graduate training in internal medicine and gastroenterology at the VA Hospital in East Orange and New Jersey Medical School in Newark. He had established a practice in Plainfield and was on the staff at Muhlenberg Hospital there, Raritan Valley Hospital in Green Brook, and the J. F. Kennedy Hospital in Edison. Dr. Alfandre was clinical assistant professor of medicine at Rutgers Medical School in Piscataway.

Dr. John G. Garbarini

Word just has been received of the death on April 19 of John G. Garbarini, M.D., a member of our Hudson County component. A native of New York City, born in 1912, Dr. Garbarini earned his medical degree from New York Medical College, class of 1937, and pursued a career in general surgery. He was a Fellow of the American College of Surgeons and of the International College of Surgeons and had been on the staff at the St. Francis and Christ Hospitals in Jersey City, the Jersey City Medical Center and the Riverside General Hospital in Secaucus.

Dr. William A. Halbeisen

On July 18 William A. Halbeisen, M.D., died at University of Pennsylvania Hospital in Philadelphia. Born in 1915, Dr. Halbeisen was graduated from Jefferson Medical College in 1941 and pursued a career in internal medicine and cardiology becoming board certified in those specialties. He had practiced in Haddon Heights and more recently in Medford Lakes, retiring in 1978 to Cape May Court House because of failing health. Dr. Halbeisen had been affiliated with Underwood Hospital in Wood-

bury, Our Lady of Lourdes Hospital in Camden and Burdette-Tomlin Memorial Hospital in Cape May Court House. In recent years he had been a consultant internist and cardiologist for the Coast Guard in South Jersey. Dr. Halbeisen was a Fellow of the American College of Physicians, of the American College of Chest Physicians, of the American College of Cardiology, and of the American College of Geriatrics.

Dr. Morris Harris

On June 27, Morris Harris, M.D., a member of our Essex County component, died at his home in Bloomfield following a heart attack. A native of New York, Dr. Harris was graduated from Syracuse University College of Medicine in 1929 and pursued a residency in ophthalmology at Long Island University College Hospital. He became board certified in that specialty and was a Fellow of the American College of Surgeons. Dr. Harris practiced for 43 years in Bloomfield and had been director of the department of ophthalmology and otolaryngology at both Mountaine and Community Hospitals in Montclair. He also was affiliated with the Newark Eye and Ear Infirmary. During World War II Dr. Harris served with the medical department of the AUS. In 1979 he was a recipient of MSNJ's Golden Merit Award indicating 50 years of medical practice. Dr. Harris was 76 years old at the time of his death.

Dr. Michael Holtzman

At the grand age of 84, Michael Holtzman, M.D., an emeritus member of the Union County Medical Society, died on July 13 in Florida where he had been living in retirement for some years. Born in Russia, Dr. Holtzman received his medical education at Long Island College of Medicine, class of 1921, and established a practice in general medicine in Elizabeth. He had been affiliated with Alexian Brothers, Elizabeth General and St. Elizabeth Hospitals. In 1971 Dr. Holtzman was a recipient of MSNJ's Golden Merit Award indicating fifty years of medical practice. He was the father of Dr. Donald J. Holtzman an

orthopedic surgeon practicing in Elizabeth and Dr. Gilbert Holtzman of Piedmont, California.

Dr. Murray Nussbaum

Murray Nussbaum, M.D., Professor of Medicine at New Jersey Medical School, CMDNJ, died on July 19 at Chilton Memorial Hospital in Pompton Plains after a brief illness. A native of New York City, born in 1927, Dr. Nussbaum earned his medical degree from the Medical School of the University of Vermont, class of 1952, and after residencies in medicine and hematology at Boston City Hospital and the New England Center Hospital in Boston came to New Jersey to establish a practice, first in Wayne and Paterson and more recently in Ridgewood. In addition to the New Jersey Medical School he had been on the faculty at Tufts University Medical School and the Seton Hall College of Medicine, and was a research associate in hematology at the Mount Sinai Hospital and Medical School in New York. He was on the active staff at the Barnert Memorial Hospital and St. Joseph's Medical Center in Paterson, Martland Hospital (now College Hospital) in Newark and the East Orange Veterans Administration Hospital, and was affiliated also with the Chilton Memorial Hospital in Paterson, Englewood Hospital, Jersey City Medical Center, Passaic General Hospital and the Valley Hospital in Ridgewood. Dr. Nussbaum contributed extensively to the literature in his field and his articles appeared in many of the major medical publications. He was a member of the Editorial Board of this *Journal*. Dr. Nussbaum was a Fellow of the American College of Physicians and of the International Society of Hematology, and a member of the American Society of Hematology, the American Federation for Clinical Research and the New York Society for the Study of Blood. He was secretary of the Medical Advisory Committee of the Board of Trustees of the Leukemia Society of America and chairman of the Medical Advisory Committee of the New Jersey Chapter of that organization.

Dr. Samuel H. Pogoloff

Samuel H. Pogoloff, M.D., a member of our Somerset County component, died on July 9 at Somerset Medical Center. He had practiced family medicine in Manville for over 56 years and was borough school physician for over 40 years. A native of Russia, Dr. Pogoloff earned his medical degree from the University of Oklahoma in 1923. He had been affiliated with Somerset Hospital and had served as president of the board of health of Manville. During World War I Dr. Pogoloff served with the medical corps of the AEF. He was a recipient of MSNJ's Golden Merit Award in 1973 in recognition of his 50 years of medical practice. Dr. Pogoloff was 90 years old at the time of his death.

Dr. George R. Read

George R. Read, M.D., a well-known member of our Essex County component, died on June 10 in Mountainside Hospital following a brief illness. Born in 1919 and a native of Newton, Massachusetts, Dr. Read earned his medical degree from Yale University School of Medicine in 1945 and pursued graduate training in surgery and urology. Before entering private practice in 1955, Dr. Read was chief of urology at the Veterans Administration Hospital in West Haven, Connecticut and an instructor in urology at Yale University School of Medicine. In New Jersey he established an office in Montclair and was director of urology at both Montclair Community and Mountainside Hospitals and a member of the staff at St. Vincent's Hospital. Dr. Read also had been president of the staff at both Community and

Mountainside Hospitals. He was a member of the Academy of Medicine of New Jersey and of the American Urological Society.

Dr. David M. Shor

One of Essex County's senior members, David M. Shor, M.D., of East Orange, died in East Orange General Hospital on July 5. A native of Massachusetts, born in 1905, Dr. Shor was graduated from Boston University's School of Medicine in 1929 and following residencies in surgery and gynecology came to New Jersey to establish a practice. He had been on the staff at East Orange General Hospital all of his professional career, and in 1979 was honored by that institution with their distinguished service award. Dr. Shor was a Fellow of the American Society of Abdominal Surgeons and of the International College of Surgeons and had been affiliated also with the Geriatric Center at Belleville, the Clara Maass Memorial Hospital there and the Community General Hospital in Hackettstown. During World War II he served with the medical department of the AUS. In 1979 Dr. Shor was a recipient of MSNJ's Golden Merit Award in recognition of his 50 years of medical practice.

Dr. Edward G. Waters

One of Hudson County's senior members, Edward G. Waters, M.D., died on July 11 at his home in Little Silver. Born in Derby, Connecticut, Dr. Waters received his medical degree from Harvard Medical School in 1922 and pursued a career in obstetrics and gynecology in Jersey City until retirement in 1976. He

was board certified in his specialty and a Fellow of the American College of Obstetricians and Gynecologists and of the American College of Surgeons. He had been affiliated with most of the area hospitals and was chief of the department of obstetrics and gynecology at the Jersey City Medical Center and the Margaret Hague Hospital. Throughout his career he had taught at Yale University School of Medicine, Harvard Medical School, New York University/Bellevue Medical School, Columbia University's College of Physicians and Surgeons and at Seton Hall University Medical School, the forerunner of the College of Medicine and Dentistry of New Jersey. Dr. Waters had published over 100 articles in scientific journals and contributed chapters to several books in his field. Dr. Waters was recipient of MSNJ's Golden Merit Award in 1972, indicating fifty years of medical practice. He was 83 years old at the time of his death.

Dr. Milton Wurzel

One of Essex County's senior members, Milton Wurzel, M.D., died on July 18 at Irvington General Hospital. A native of New Jersey, Dr. Wurzel earned his medical degree from the University of Maryland School of Medicine in 1928 and returned to New Jersey to practice family medicine in the Newark area until retirement in 1971. He had been affiliated with Doctors' and Beth Israel Hospitals in Newark. During World War II, Dr. Wurzel served with the medical department of the AUS. In 1978 he was a recipient of MSNJ's Golden Merit Award in recognition of his fifty years as a physician.

What To Do When You Think You Can't Have a Baby

Karol White. New York, Doubleday, 1981. Pp. 215. (\$11.95)

The tide of consumerism continues to rise as exemplified by this well-written "how-to" handbook. Practically all aspects of infertility are covered and the advice offered is usually reasonable. However, the author postpones until the third month of management the Sims-Huhner Postcoital Test which can be performed easily by any physician at the first or second visit. This bit of erroneous advice cannot be overlooked because a negative result requires further diagnostic and therapeutic measures promptly while a positive result provides reassurance to the female and especially the male. Here lies the trap into which many lay authors stumble when trying to write on medical subjects. Despite abundant consultation (in this case there are thirty-three infertility specialists) it is clinical experience that enables the sorting out and evaluation of medical information. The author conjures up the image of an all-knowing infertility expert, psychiatrically oriented, replacing the parent already too often denigrated by the march of science and modern sexuality, devoted a la "Marcus Welby" to the resolution of each case of infertility. Despite the claim of "honesty" this handbook's emphasis upon success cannot help but raise false hopes among the irreversibly sterile. It probably is not feasible to offer the laity a textbook without spicy anecdotes which detract from its serious purpose. Nevertheless,

frivolous anecdotes as well as a few minor errors of misplaced emphasis should not dissuade the physician from recommending this book to those patients who might derive a better perspective of a problem that has increased significantly in severity and frequency during the past twenty years.

Jerome Abrams, M.D.

Current Surgical Diagnosis and Treatment, 5th ed.

Editors: J. E. Dunphy, M.D. and L.W. Way, M.D. Los Altos, CA, Lange, 1981. Pp. 1138. Illustrated. (\$25)

The fifth edition of this surgical text makes available in concise form the basic information and the most recent developments in general surgery and each of the surgical specialties for medical students, residents, and practicing surgeons and physicians.

New information has been added to all chapters and the bibliographies have been updated and expanded. Some chapters have been completely rewritten—postoperative problems, anesthesiology, shock, congenital heart disease and otolaryngology. Substantial revisions have been made in the chapters on the breast, acquired heart disease, esophagus and diaphragm, stomach and duodenum, portal hypertension, the biliary tract, and oncology and cancer chemotherapy.

This soft-covered book represents an excellent summary of current concepts and it is hoped that new editions will be made available every two years.

Stanley S. Fieber, M.D.

Prenatal Diethylstilbestrol (DES) Exposure: Recommendations of the Diethylstilbestrol-Adenosis (DESAD) Project for the Identification and Management of Exposed Individuals

U.S. Dept. of Health and Human Services. Bethesda, M.D., National Institutes of Health, 1981, NIH Publication No. 81-2049. No charge.

Physicians caring for offspring exposed prenatally to DES are offered this concise, attractive pamphlet without charge. Over seventy non-steroidal estrogen compounds that were prescribed frequently for high-risk pregnancies between 1940 and 1971 are listed by trade name. Although vaginal and cervical pathology is rare among DES-exposed daughters and actual malignancy less than 0.1 percent, the relative incurability of clear cell adenocarcinoma, which does not present early clinical manifestations, obliges all responsible clinicians to gain an acquaintance with a few simple diagnostic procedures so well described and illustrated. A quick perusal of this invaluable pamphlet will permit the internist, pediatrician or family physician to determine which patients readily can be screened and which patients should be referred to the gynecologist for specific diagnostic as well as therapeutic procedures.

Jerome Abrams, M.D.

FANTASTIC OPPORTUNITY!!!

BUY OR LEASE

Attractive 12,000 sq ft, 3 story elev professional bldg delivered vacant for immediate occupancy. Located just off a Rte 21 Interchange and one half block from the new City Hall in Passaic, NJ. Approx 4 separate suites per floor, ea w/individual heat/AC systems. 1st floor has space for commercial use such as pharmacy, etc. And best of all, the entire "operation" is realistically priced!

RACHLIN & CO, Realtors

Management Division/Our 76th Yr.
17 Academy St., Newark, NJ 07102
(201) 622-7890

JACKSON, NEW JERSEY

Office space to rent or share in center with two groups of obstetricians, one general surgeon, one nephrologist. Ideal for someone starting in practice.

Call 201-477-2727 or 201-892-9499

LEASE PROFESSIONAL BUILDING

1148 Parsippany Blvd., Parsippany, NJ

Former estate situated on 1.8 acres off Rts. 46, 202, 287, 80, 280, ready for leasing. Two floors of 1,200 sq. ft. each, net/net, plenty of storage and new parking. Adjoining new federal 250 unit senior citizen building.

Gallo & DeCrocce, Realtors, 113 Parsippany Road, Parsippany. Tel: 201-887-1560.

MEDICAL/PROFESSIONAL OFFICE

- One block from PAUL KIMBALL HOSPITAL
- On major highway Route 9, Lakewood, N.J.
- Reasonable Terms
- Ample parking space
- 1300-2100 square feet availability

CALL (201) 542-3382

Monday-Friday 9 AM-5 PM

MAGNIFICENT ESTATE



Elegant mansion gracefully set on 2 plus Acres w/panoramic view, professionally decorated thruout. Dramatic Reception Hall with sweeping Antebellum staircase leads to 20 x 40 Living Rm w/fireplace, Dining Rm, Library, Powder Rm, Cheerful Solarium and more! New Gas 4 Zone heating system w/heat pumps and 4 Zone Central Air results in low utility costs. Added Bonus—Carriage House w/3 Rm Apartment and 3 Car Garage w/electric door. \$450,000.

Located in North Caldwell, N.J., a prestigious community just 20 minutes to Lincoln Tunnel and George Washington Bridge.

Close to Rts. 280, 287, 80, 23, 46, 10 with convenient Bus and Train Transportation.

For Additional Information Call Broker
LEON REAL ESTATE CO. (201) 228-5503

2 year "new" CALIFORNIA CONTEMPORARY



Set high on a hill behind tall trees, on 1 1/3 acres in naturalistic setting. Spectacular Entrance Hall, Sunken Living Room, beamed Cathedral ceilings, two fireplaces, wrap-around sundeck with panoramic view from Family Room, glass walled Breakfast Room and Master Bedroom Suite, 3 additional Bedrooms, 4 glamorous Baths on first floor totaling 3,700 sq. ft. Ground level has separate entrance totaling 2,000 sq. ft. with lavatory, 4 rooms and large 54 x 29 ft. room.

Many luxurious and practical features too numerous to mention, plus 5 zone Hot Water Baseboard Heat.

Convenient bus and train transportation. 20 minutes to Lincoln Tunnel and George Washington Bridge in prestigious community of North Caldwell.

Available at \$375,000.

LEON REAL ESTATE CO. 228-5503

**SNOWMASS/VAIL "MEP" SKI SEMINAR ON
MANAGEMENT ENRICHMENT FOR THE
HEALTH PROFESSIONAL**

Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or ski Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Trip expenses deductible for doctor and spouse. For information: MEP, An Education Corporation, 906 Cooper Avenue, Glenwood Springs, Colorado 81601; or 1-800-525-3402.

CME
See 633, 699-703

Real Estate
See 707

REDWOOD DECKS

Call Mike
The Fancy Deck Builder
(201) 595-6263

NEEMA EMERGENCY MEDICAL
—a professional association—

Emergency Medicine Positions—available with emergency physician group in PA, NY, NJ, VA, WV, KY, MD and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical
Suite 400 or phone
399 Market Street in Pa., (215) 925-3511
Philadelphia, Pa. 19106 outside Pa., 800-523-0776

**THE JERSEY SHORE MEDICAL CENTER
DEPARTMENT OF MEDICINE**
announces the
SEASHORE SYMPOSIUM

**"CONTROVERSIES IN
CANCER MANAGEMENT"**

Friday, October 30, 1981
Saturday, October 31, 1981

HILTON INN

Tinton Falls, New Jersey 07753

Guest Speakers:

Emil J Freireich, M.D.	Daniel S. Martin, M.D.
The University of Texas	Sloan-Kettering Cancer Center
System Cancer Center	Franco Muggia, M.D.
	New York University
Robert L. Goodman, M.D.	Samuel Pilnik, M.D., P.C.
University of Pennsylvania	F.A.C.S.-F.I.C.S.
School of Medicine	Lenox Hill Hospital

For Information Contact:

Karen Kiley
Jersey Shore Medical Center
Department of Medicine
(201) 775-5500, extension 434

Fee: \$35.00

9 Category I Credit Hours

**RESIDENCY IN
PHYSICAL MEDICINE
AND REHABILITATION**

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$17,500 to \$20,100 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

CLASSIFIED ADVERTISEMENTS

HAEMATOLOGIST/ONCOLOGIST—Seeks practice opportunities in field of subspecialty. University trained. BC/BE, FMG. Write Box No. 264, c/o JOURNAL MSNJ.

INTERNIST—Cardiologist, young, interested in joining practice in New Jersey. Strong university training. Board certified in internal medicine. Extensive experience clinical, invasive and non-invasive cardiology. A. Losardo, M.D. (212) 645-5190.

INTERNIST—Training and experience in hematology/oncology. ABIM, U of P Med. Wishes to associate or buy. Write Box No. 241, c/o JOURNAL MSNJ.

INTERNIST—Board eligible, seeks outpatient position (health service, clinic, other) in northern New Jersey. (516) 889-7163 or write N.H. Caplan, M.D. 27 West Penn Street, Long Beach, N.Y. 11561.

INTERNIST—Board certified, 29, practicing two years. Desires to relocate in New Jersey. Seeks solo, group, partnership or buy established practice. Available July 1982. Write Box No. 265, c/o JOURNAL MSNJ.

INTERNIST—BE, desires relocation to southern NJ. Industrial or private practice situations will be considered. (717) 846-5936 or reply to: T.N., 367 Hill-N-Dale Dr. N., York, PA 17403.

M.D.—Board eligible, not yet licensed. Seeks position as assistant or hospital employment. Graduate Preparing Medical College 1954. Write Box No. 259 c/o JOURNAL MSNJ.

OB/GYN—Board eligible. Desires partnership, group, fellowship fulltime instructor. Available now. Telephone (212) 347-5228.

OTOLARYNGOLOGY—Board certified with broad experience. Seeking group, partnership; will consider solo. Available August 1982. Write Box 269, c/o JOURNAL MSNJ.

NEEDED—General Internist to join growing multi-specialist group practice in New Jersey. Superior diagnostic facilities with own lab and x-ray. Privileges at university affiliated hospital. Salary, benefits negotiable. Immediate opening. Write Box No. 263, c/o JOURNAL MSNJ.

PEDIATRICIAN—To associate with another pediatrician. Excellent opportunity. Essex County. Write Box No. 266, c/o JOURNAL MSNJ.

WANTED—OFFICE EQUIPMENT—Examining tables and any other office equipment and supplies for use in general medical practice. Allan Lazar, M.D., P.O. Box J, Teaneck, NJ 07666. (201) 568-3742.

PEDIATRICIAN—Wishes to buy active practice in NJ or become associate with a pediatrician. Would also consider position in medical group. Board eligible, hospital affiliated. Write Box No. 267, c/o JOURNAL MSNJ.

OPHTHALMOLOGIST—Wishes to purchase or associate with an ophthalmology practice in New Jersey. Please contact Box 268, c/o JOURNAL MSNJ.

PRACTICE FOR SALE—Englewood Hospital Area, Bergen County. Internal Medicine and Family Practice. Practice is large enough to support 2 physicians. Principals only. Building and equipment negotiable. Write Box No. 262 c/o JOURNAL MSNJ.

FOR SALE—PEDIATRIC PRACTICE—Pediatrician entering academic medicine. Thriving, varied practice, shore area. Opportunity to join as associate before acquisition. Practice easily expandable to two physicians. Purchase terms very negotiable. Write Box No. 258, c/o JOURNAL MSNJ.

FOR SALE—Hawthorne. Long established OB/GYN practice and office equipment/furnishings for sale immediately due to illness. Convenient to two new hospital facilities. Located in Hawthorne with off-street parking in rear. If interested, please call (201) 423-3988 between 11 a.m. and 4 p.m.

FOR SALE—Home/Office. North Bergen County, luxury custom built with 4 bedrooms, 2½ baths, liv/rm, din/rm, den w/fireplace, pool and cabanas. Main thoroughfare. Many extras. Office has 500 sq ft incl. 2 treatment rooms, bath, 2 entrances. Off-street parking, waiting rm, nurse and private office. Excellent location. No practice for sale. (201) 569-4770.

FOR SALE—Southern NJ. Fully equipped 8 room medical office with 2 rental apartments. In a doctor-shortage area close to Philadelphia. Phone Mrs. S. Lintz, (609) 467-0466 or write Box 157, Swedesboro, N.J. 08085.

FOR SALE—Professional Office Building. Irvington, NJ. Center of town, one block from Garden State Parkway and bus terminal. Modern brick, A/C, ten years old, ample parking, multiple office suites on two floors, separate entrance each floor, elevator. Call Mrs. Jaffe, Monday-Thursday (201) 399-7796.

OFFICE SPACE—Physician's office for rent, suburban area, on main road. Call (201) 887-7492 or (201) 887-1628 after 5 p.m.

OFFICE SPACE—Berkeley Heights. For rent in medical office centrally located, ample parking. Call (201) 376-8511 afternoons.

OFFICE SPACE—Englewood. 1200 feet, can be divided. Ideal for psychiatrists and surgical specialties. Two blocks from Englewood Hospital. Ample parking. Call (201) 568-1441.

OFFICE SPACE—Kenilworth. For rent in medical office. Call (201) 272-5750.

OFFICE SPACE—Montclair. 1200 feet, large waiting room, business office, three examining rooms. Commercial district, two blocks from Mountainside Hospital. Adequate parking. Call (201) 744-4941.

OFFICE SPACE—Doctor's office for rent, on main bus line. Large spacious reception room, two examining rooms, rest room, large consultation office. All fully equipped. Ready for immediate occupancy. Call (201) 333-8556.

OFFICE SPACE—Roxbury Twp. Morris County. Prime location on Rt. 10. Tenants include large pediatric group, lawyer, architect, realtor. One 1356 square foot suite available. \$10/sq. ft. including all utilities, two smaller office on lower level at \$7/sq. ft. offices. Ideal office for dentist, podiatrist, ob-gyn, ent. Air conditioning, carpeting, ample parking, easy access, storage available. Dr. Elliott Milgram (201) 584-9390.

OFFICE SPACE—East Rutherford, Wallington area. Available, doctor's office, 7 rooms including 3 treatment, lab, consulting, nurse's, waiting. Excellent neighborhood. Polish speaking clientel. Also available excellent doctor's residence next door. Telephone (201) 471-4213.

OFFICE SPACE—Rental, attractive private office, 200 sq feet available with furnished shared space of 550 sq ft, including waiting room, secretarial office and bath. Prime location, ample parking, utilities supplied. Wayne Medical Center, 1777 Hamburg Tpk, Wayne, NJ, near Rts 80 and 23. (201) 839-3036.

INFORMATION FOR MEMBERS—RATES—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT**: Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JOURNAL MSNJ" as six words. **COPY DEADLINE**: Fifth of preceding month.

SPECIFY
ZYLOPRIM[®]
(allopurinol)
THE
ORIGINAL
ALLOPURINOL



Two convenient dosage forms:
100 mg (white) and 300 mg (peach)
Scored Tablets



Tablets imprinted with brand name to
assist in tablet identification.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

October 1981

Journal of
the Medical
Society of

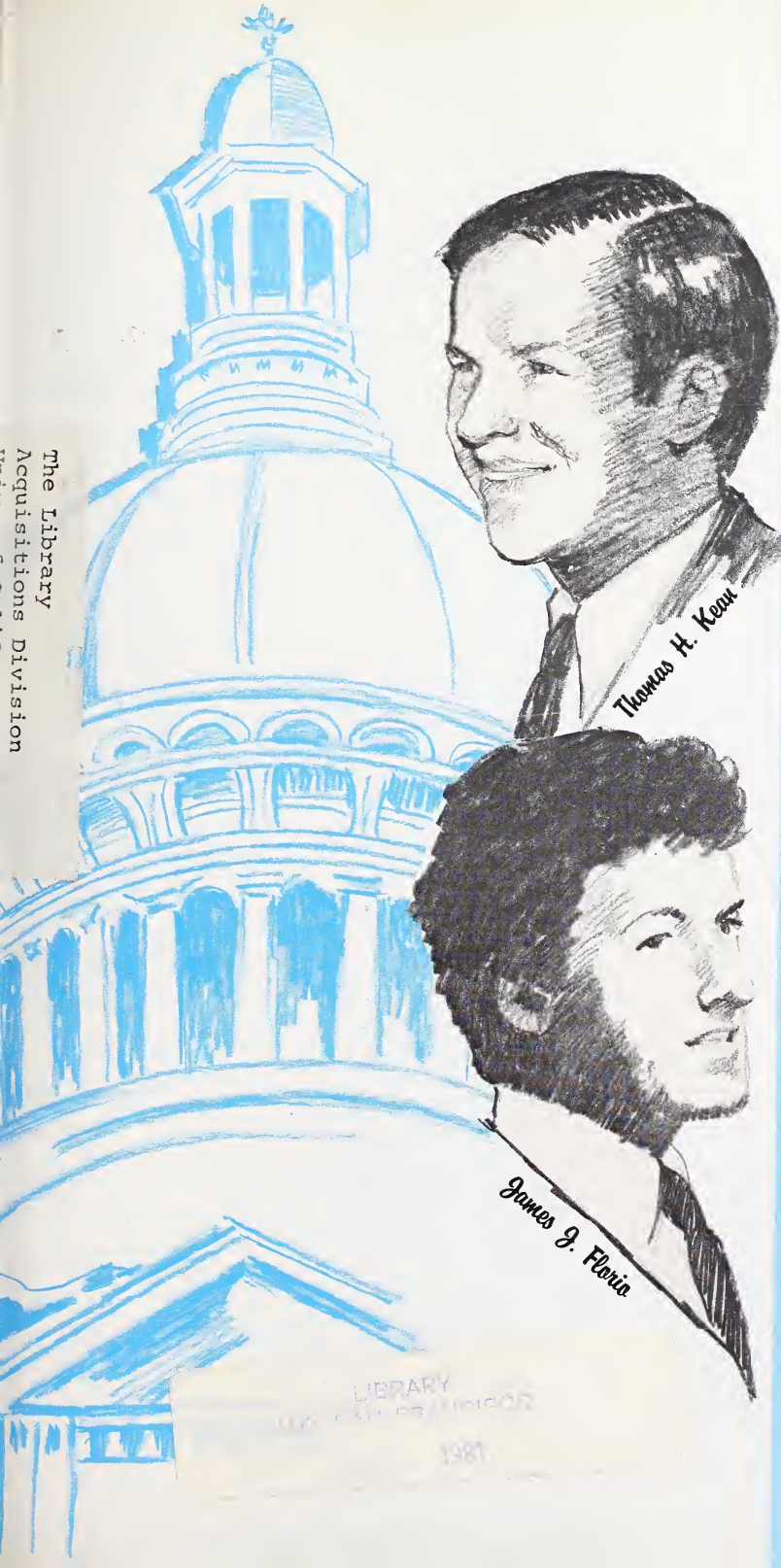
New Jersey

Neuroendocrine Diagnostic
Tests in Psychiatry
I. Extein, M.D., et al.

Prolactin: Parts I and II
*E. Kemmann, M.D.
J. R. Jones, M.D.*

Diuretic Therapy
R. Dodelson, M.D., et al.

Nineteenth Century Drug
Therapy
D. L. Cowen, M.A., et al.



Thomas H. Keen

James G. Florio

The Library
Acquisitions Division

LIBRARY
CALIFORNIA
1981

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

***Check this list
against your
coverages***

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$7,500 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____

**VOTE.
IT MIGHT
BE WORTH
THE
BOTHER.**

NOVEMBER 3, 1981

A Public Service of JEMPAC and
The Advertising Council

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



Officers and Trustees

PRESIDENT	Armando F. Goracci, M.D. (Gloucester)	Woodbury
PRESIDENT-ELECT	Howard D. Slobodien, M.D. (Middlesex)	Perth Amboy
FIRST VICE-PRESIDENT	Alexander D. Kovacs, M.D. (Union)	Scotch Plains
SECOND VICE-PRESIDENT	Frank Y. Watson, M.D. (Essex)	Montclair
IMMEDIATE PAST-PRESIDENT	Augustus L. Baker, Jr., M.D. (Morris)	Dover
SECRETARY	Arthur Bernstein, M.D. (Essex)	East Orange
TREASURER	Rudolph C. Gering, M.D. (Mercer)	Pennington

Trustees

CHAIRMAN	
William Greifinger, M.D. (1984) (Essex)	Belleville
Meyer L. Abrams, M.D. (1982) (Burlington)	Cherry Hill
Frank Campo, M.D. (1984) (Mercer)	Trenton
Douglas M. Costabile, M.D. (1984) (Union)	Murray Hill
John J. Crosby, Jr., M.D. (1984) (Hudson)	Jersey City
Anthony P. DeSpirito, M.D. (1982) (Monmouth)	Neptune City
Ralph J. Fioretti, M.D., (1983) (Bergen)	Rochelle Park
Palma E. Formica, M.D. (1984) (Middlesex)	Old Bridge
Harry W. Fullerton, Jr., M.D. (1982) (Salem)	Carney's Point
Sherman Garrison, M.D. (1983) (Cumberland)	Bridgeton
John P. Kengeter, M.D. (1984) (Ocean)	Toms River
Myles C. Morrison, Jr., M.D. (1982) (Morris)	Morristown
Michael R. Ramundo, M.D. (1984) (Passaic)	Clifton
Bernard Robins, M.D., (1983) (Essex)	Springfield

Councilors

FIRST DISTRICT	(Essex, Morris, Union, and Warren Counties)
Edward M. Coe, M.D. (1984)	Cranford
SECOND DISTRICT	(Bergen, Hudson, Passaic, and Sussex Counties)
Robert A. Weinstein, M.D. (1983)	Newton
THIRD DISTRICT	(Hunterdon, Mercer, Middlesex, and Somerset Counties)
Albert F. Moriconi, M.D. (1982)	Trenton
FOURTH DISTRICT	(Burlington, Camden, Monmouth, and Ocean Counties)
Frederick W. Durham, M.D. (1984)	Haddonfield
FIFTH DISTRICT	(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)
Ronald M. Fisher, M.D. (1983)	Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982)	Hackensack
William J. D'Elia, M.D. (1981)	Spring Lake
Frederick W. Durham, M.D. (1982)	Haddonfield
Karl T. Franzoni, M.D. (1982)	Trenton
John S. Madara, M.D. (1982)	Salem
Henry J. Mineur, M.D. (1982)	Cranford
Myles C. Morrison (1981)	Morristown

October 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Julio C. del Castillo, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.
Harold Arlen, M.D.
Alfonse Cinnotti, M.D.
Stuart D. Cook, M.D.
Robert Dodelson, M.D.
Wm. A. Dwyer, Jr., M.D.
Norman H. Ertel, M.D.
A. Olusegun Fayemi, M.D.
Arthur Goldfarb, M.D.
Robert A. Goldstone, M.D.
Murray Kahn, M.D.
Monroe S. Karetzky, M.D.
Avrum L. Katcher, M.D.
Sidney Ketyer, M.D.
Bernard J. Koven, M.D.
Joel D. Levinson, M.D.
Henry R. Liss, M.D.
Robert M. MacMillan, M.D.
Geobel A. Marin, M.D.
Christopher M. Papa, M.D.
Victor Parsonnet, M.D.
Irwin Pollack, M.D.
Bernard A. Rineberg, M.D.
Edwin L. Rothfeld, M.D.
Benjamin F. Rush, Jr., M.D.
Morris H. Saffron, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Sheldon D. Solomon, M.D.
Lloyd N. Spindell, M.D.
A. Arthur Sugerman, M.D.
Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 929. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies \$1. Address communications to *The Journal MSNJ*, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

First Class First Aid



In
their
homes

Recommend

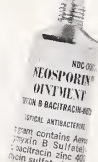
NEOSPORIN® Ointment (POLYMYXIN B-BACITRACIN-NEOMYCIN)

- Broad-spectrum antibacterial
- Handy applicator tip

INDICATIONS: Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), bacitracin zinc 400 units. In tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

CONTRAINDICATIONS: For use in the eyes or in the external ear canal if perforated. This product is contraindicated in those individuals with hypersensitivity to any of its components.

PRECAUTIONS: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, ototoxicity and nephrotoxicity have been reported (see Warning section). Overuse and other extensive conditions where absorption of neomycin is possible.



PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

718 **PROFESSIONAL LIABILITY COMMENTARY**

EDITORIALS

722 PRN 1981—66: Dangerous Medicaid Regulation

723 Teenage Nutrition

724 Florio vs. Kean

727 **JEMPAC REPORTORIAL**

ARTICLES

731 Neuroendocrine Diagnostic Tests in Psychiatry
I. Extein, M.D.; A.L.C. Pottash, M.D.; M. S. Gold, M.D., Summit

737 Infant Feeding Practices by Ethno-Cultural Grouping
R. M. Russo, M.D., New Brunswick; R. Patel, M.D.; T. A. Laude, M.D.; S. V. Rajkumar, M.D., Brooklyn; V. J. Gururaj, M.D., Lubbock, Texas

REVIEW ARTICLES

741 Part I: Prolactin and Its Physiology
E. Kemmann, M.D.; J. R. Jones, M.D., Piscataway

743 Part II: Hyperprolactinemia—Diagnosis and Management
E. Kemmann, M.D.; J. R. Jones, M.D., Piscataway

STATE OF THE ART

748 Diuretic Therapy
R. Dodelson, M.D., East Brunswick; R. Sherman, M.D., Westfield; N. E. Gary, M.D.; R. P. Eisinger, M.D., Piscataway

CASE REPORTS

751 Bilateral Synchronous Primary Lung Cancer
J. Goldshlack, D.O.; B. A. Safirstein, M.D., Newark

754 Giant Left Atrium with Massive Mural Thrombus in Patient with Mitral Stenosis
N. L. DePace, M.D.; A. Elguezabal, M.D.; M.N. Kotler; B. Wagner, M.D., Philadelphia

MEDICAL HISTORY

758 Nineteenth Century Drug Therapy
D. L. Cowen, M.D.; L. D. King, Ph.D.; N. G. Lordi, Ph.D., Piscataway

762 **NUTRITION UPDATE**

765 **THERAPEUTIC DRUG INFORMATION**

767 **SPECIAL COMMITTEES AND LIAISON REPRESENTATIVES—1981-1982**

770 **DOCTORS' NOTEBOOK**

770 CMDNJ Notes

771 Physicians Seeking Location in New Jersey

774 **216th ANNUAL MEETING—Daily Schedule**

775 **LETTERS TO THE JOURNAL**

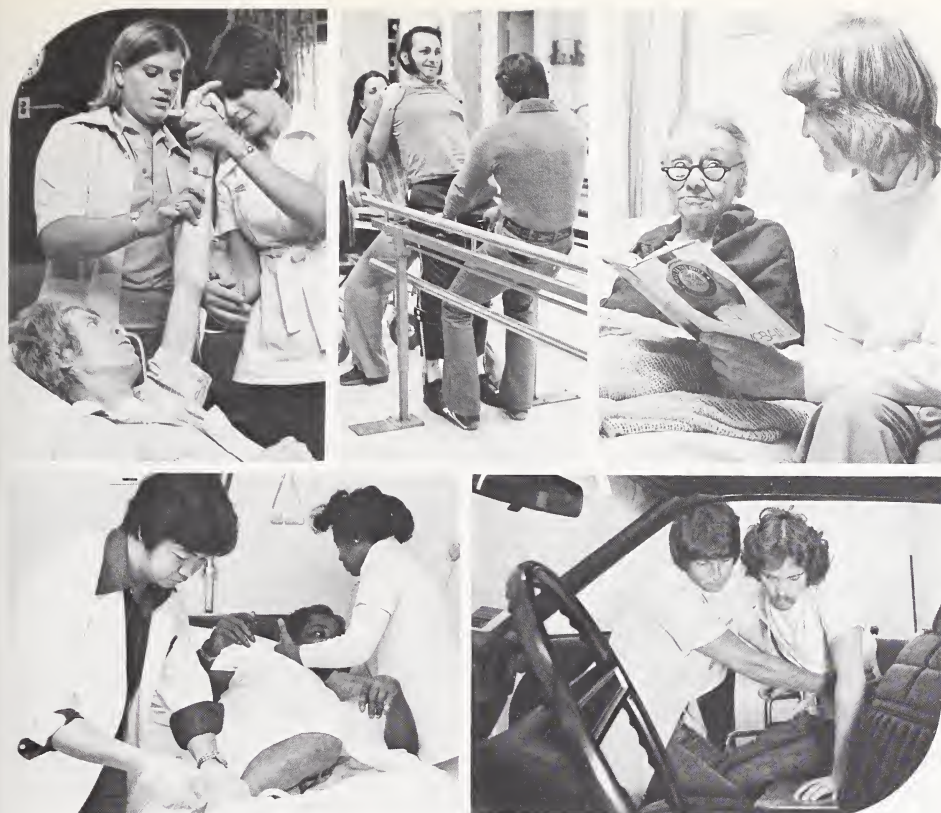
777 **CME CALENDAR**

783 **OBITUARIES**

785 **1982 JOURNAL RATE CARD**

Cover

The cover is an original drawing by Elizabeth Ruggles, a well-known teacher and artist in the Trenton area, formerly on the staff of the New Jersey State Department of Health.



Rehabilitation is a Team Effort

New Jersey Rehabilitation Hospital, located by Exit 145 of the Garden State Parkway, is a specialty hospital which treats catastrophic injuries to spinal cord and brain, stroke, quadriplegia, paraplegia, loss of limb, musculo-skeletal injuries, neck and low back injuries, and other mental and physical impairments, often resulting from automobile or work accidents.

The goal of rehabilitation is to return disabled patients to an optimum productive life, and this involves a total team effort on the part of rehabilitation doctors, nurses, therapists, the family physician, and other specialists in the rehabilitation process. Thanks to this total team effort, NJR's patients are succeeding despite their handicaps.

To arrange for an escorted tour of our facilities, call Bucky Harris, at (201) 673-1860. We believe you'll be impressed with modern rehabilitation medicine.



New Jersey Rehabilitation Hospital

Owned and operated by Moderncore Centers of America, Inc.

240 Central Avenue, East Orange, NJ 07018 • 201-673-1860

Bertrand J. Bensam, MD, Medical Director • Stanley Shepard, Administrator

Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities and the American Board for Certification in Orthotics and Prosthetics Inc.

Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white glossy

prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source. Written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

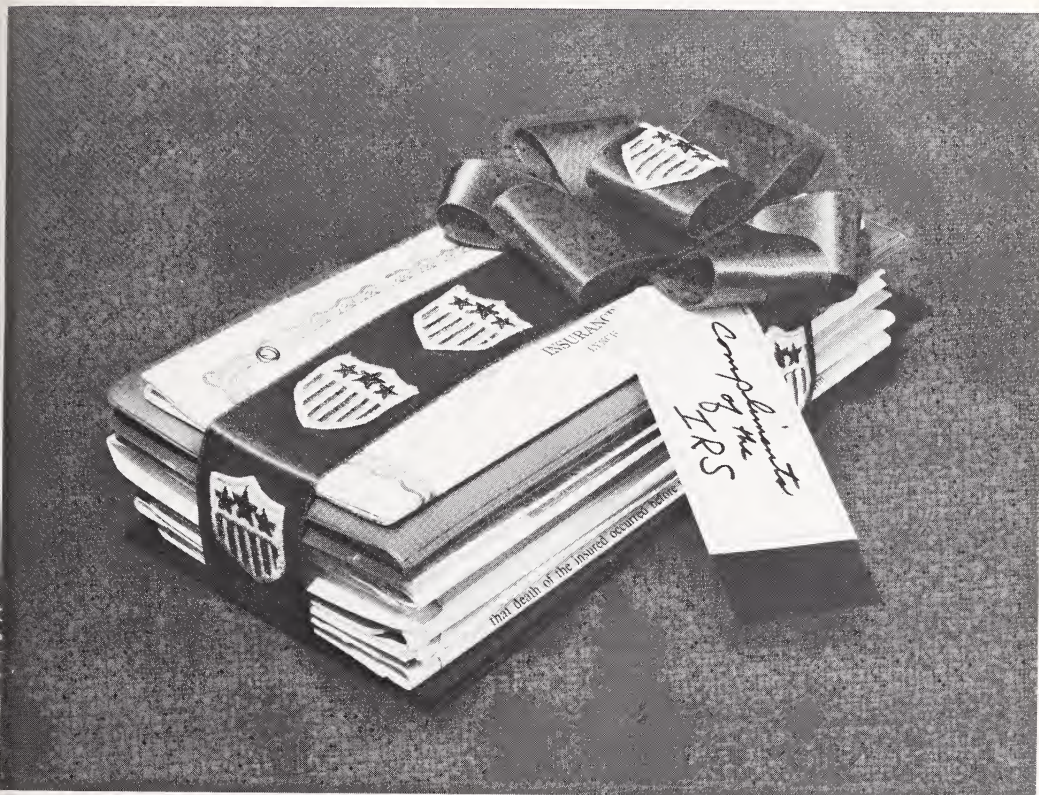
REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.

How would you like Uncle Sam to pay for 100% of your life insurance...



and pay you a bonus for owning it?

Seem far fetched? It isn't. It not only can work, but it *does* work—as we've proven to many of our clients. And the entire procedure is fully supported by revenue rulings and sections of the internal revenue code.

In essence, this innovative concept developed by Richard G. Halpern Associates, works by allowing you to make a profit in the form of multiple deductions on both your income and estate taxes.

The concept does not fit everyone. It's designed for professional practices functioning within specific parameters. But it works in a surprising number of cases—and could well work in yours.



The point is, it will cost you nothing except a few minutes of your time to find out. We'd welcome the opportunity to discuss the plan with you at your convenience. Just call Rich Halpern at (201) 379-6723.

There's no obligation, of course, and all inquiries will be kept strictly confidential.

**RICHARD G. HALPERN
ASSOCIATES, INC.**

44 Fernhill Road, Springfield, New Jersey 07081

Featuring: Multiple Interpretations of Phrases Commonly Used by Doctors

STUDY REVEALS MULTIPLE INTERPRETATIONS OF PHRASES COMMONLY USED BY DOCTORS

There is wide divergence between what doctors think they say and what patients think they mean, according to a recent study conducted by seven graduate students at Case Western Reserve University School of Medicine in Cleveland, Ohio.

Results of the study strongly suggest that patients have different interpretations of doctors' remarks and doctors have different intent by their comments. The study was directed by Marcia Z. Wile, Ph.D., assistant professor of medical education research at Case Western Reserve.

For the study, the students first chose ten nontechnical phrases commonly used in doctor-patient conversations:

- Going home from the hospital soon
- Take this medication as needed
- If you have a reaction
- It's not serious
- You don't have to worry
- Just a minute
- If you have trouble, call me
- Take care of it now

Next, a pilot test was conducted. A group of doctors and potential health care recipients (referred to as patients) were asked to state the meaning of each phrase. Their verbatim responses then were used to construct a series of alternative interpretations for the ten phrases.

Finally, a multiple choice response form was developed for the study. Using this form, 70 northeastern Ohio patients and 58 doctors and third-and-fourth-year medical students selected the response that most closely reflected their personal interpretation.

The doctors and medical students were asked to select the response which most accurately represented the meaning they intended to convey when using the various phrases. The patients were asked to indicate the response which best represented their understanding of each phrase.

The study revealed multiple interpretations of the phrases within the patient group, within the doctor/medical student group and between the two groups, Wile said.

The study confirmed the concept that communication is still a two-way street. "It's hardly a new idea, but as health care professionals, we should be asking ourselves if we're providing a feedback mechanism," Wile said.

"Doctors," Wile added, "may need to allot more time to exploring a patient's comprehension by asking: What do you understand this to mean?" By the same token, she emphasized, "Patients must assume some responsibility in the communication process."

Before reading more about the study, you may want to respond to the phrases yourself. Selected findings in the study are:

—Almost 90 percent of the doctors interpreted the phrase "going home from the hospital soon" to mean either "two to

four days" or "an indetermined time." However, almost 20 percent of the patients considered the phrase to mean "tomorrow." (The dictionary definition of the word "soon" is "at once, immediately, before long, without undue time lapse, promptly, speedily.")

—With regard to the phrase "take this medicine as needed," many doctors qualified their responses by stating that medicine would always be prescribed for a specific purpose. However, almost two-thirds of the patients seemed to equate medicine with pain or discomfort.

—There was general agreement between doctors and patients about the phrase "if you have a reaction." Nearly half of the doctors (45 percent) and half of the patients (47 percent) considered the phrase to mean "if something unexpected occurs."

—Ninety percent of the doctors and 79 percent of the patients interpreted the phrase "it's serious" to mean "it needs immediate attention." Almost all of the other doctors (5 percent) and patients (16 percent) said the phrase means "you'll have to be hospitalized."

—In the case of the phrase "it's not serious," the majority of doctors (77 percent) and patients (66 percent) took the phrase to mean "the illness is mild." Another nine percent of the doctors and 12 percent of the patients said the phrase means "it'll go away by itself in a few days."

—Nearly two-thirds of the doctors and patients understood the phrase "you don't have to worry" to mean "illness is slight" or "it's treatable." However, four percent of the doctors and 14 percent of the patients considered the phrase as "false reassurance."

—Interpretation of the phrase "it'll only hurt a little" ranged from "a quick pinch," to "it'll probably hurt a lot." The latter was the response of 20 percent of the patients, but only two percent of the doctors.

—For the phrase "just a minute," more than one-third of the patients interpreted the phrase somewhat cynically as meaning "30 seconds to 30 minutes." For the most part, however, the doctors took the phrase to mean either a very precise "minute or two" (30 percent) or "an indefinite time" (31 percent). Still, about 20 percent of the doctors and the same percentage of patients understood the phrase to mean "five minutes."

—There was significant difference in the response to the phrase "if you have trouble, call me." Approximately 60 percent of the doctors interpreted this to mean "if the treatment doesn't work and you get sicker." However, only 30 percent of the patients chose the same response. Eight percent of the patients took the phrase to be a brush-off.

—Finally, 54 percent of the doctors and 64 percent of the

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

patients said "take care of it now" means "don't put it off." The next largest percentage of the doctors (23 percent) and patients (20 percent) said the phrase means "do it the same day." Reprinted from *Malpractice Digest*, May 1981, Published by St. Paul Fire and Marine Insurance Co.

DESCENDANTS CAN COLLECT DAMAGES NOT RECOVERED IN THE ORIGINAL SUIT

A patient, who underwent subtotal thyroidectomies in 1960 and 1965, filed a malpractice suit against her physician alleging negligent surgical procedures causing damages to, and removal of, her parathyroid glands resulting in hypocalcemia. A jury returned a verdict of \$100,000 in favor of the patient.

In March 1974, the patient died and two years later the patient's parents and child filed a wrongful death action against the physician alleging the death was due to the physician's malpractice established in the prior action.

The issue was brought before the Appellate Court which concluded that a wrongful death action was a separate and independent right of action in the patient's survivors and they could recover funeral expenses, burial expenses and pecuniary value of lost services, including the deprivation to the patient's daughter of her mother's care, nurture, and guidance during maturity.

This decision, as previously reported in the May 1980 Commentary (*J Med Soc NJ* 77:324, 1980), was to be appealed to the NJ Supreme Court.

In July 1981 the high court, in a decision written by Justice Morris Pashman, decided 6 to 1 that the parents could maintain their suit against the physician who was found liable for the death of their daughter. This decision permits the descendants to collect for damages not recovered in the original suit.

DID YOU KNOW

... Physicians practicing in urban areas traditionally have had greater exposure to possible litigation than their counterparts in rural practice. A recent study, conducted by the Pennsylvania Medical Society Liability Insurance Company, indicates that there is a greater chance of urban area litigation starting as a formal law suit as opposed to rural area litigation which usually starts as an informal claim.

... Donald R. Lannia, M.D., an orthopedic surgeon and an orthopedic team physician for the Minnesota Vikings, offers the following regarding failure to diagnose a fracture: "failure to x-ray at the time of injury; failure to take adequate views or to cover the proper area; and for failure to correctly interpret films that were not taken properly." (*Malpractice Digest*, November/December 1980)

... A Florida law enacted in July 1980 requiring losers in medical malpractice cases to pay the winners' legal fees, has resulted in a 20 percent decrease in claims filed with the state's physician-owned insurance company. "The company president speculates that plaintiffs' attorneys, who work on a contingency basis, are becoming more selective in accepting cases." (*Medical Economics*, June 8, 1981)

... In Illinois a verdict of \$9 million was awarded to a 46-year-old woman who became a spastic quadriplegic as a result of an anoxic episode during a rhinoplasty. The jury awarded \$2.5 million for past and future medical expenses, and an additional \$6.5 million for pain and suffering.

... A New Jersey hospital is under court order to turn over 44 patient records to state medical examiners investigating two doctors charged with performing unnecessary

surgery. Even the local PSRO, whose review first turned up the unusually high number of lumbar laminectomies and Harrington rod procedures, objected to the breach of confidentiality. The court ruled, however, that protecting public interest outweighed privacy rights. (*Medical Economics*, July 20, 1981)

... One malpractice suit in four charges failure to diagnose, reports the nation's largest medical liability insurer. The St. Paul Companies compiled this list of most common complaints from a study of claims filed from 1973 through 1980 against its policyholders.

Failure to Diagnose	Number of Claims
Fracture or dislocation	1,235
Cancer	882
Pregnancy-related problems	510
Infection	469
Foreign body	331
Circulatory ailments	316
Abdominal problems	277
Appendicitis	265
Myocardial infarction	202
Non-malignant tumor	174

(*Medical Economics*, August 10, 1981)

... In Indiana, reform legislation enacted in the mid-1970s limits recovery on any injury or death to \$500,000—the first \$100,000 of which is paid by the physician's insurance company and the remainder by a state-run Patient Compensation Fund. So far, the reform legislation has withstood the test of several constitutional challenges ... (*Malpractice Lifeline*, July 22, 1981, Vol 6, No.7)

GOVERNMENT-PREScribed STATE SCREENING PANELS

Senator Daniel K. Inouye (D, Hawaii) has revised proposals for government-prescribed state screening panels. Though the idea hasn't attracted much public attention this year, a federal solution to the problem of escalating costs of medical malpractice awards and medical professional liability insurance has surfaced again.

Last January Senator Inouye reintroduced a slightly altered version of his Health Care Protection Act of 1980, which would have set up uniform standards for "a network of health care malpractice screening panels across the nation."

The 1981 bill, S. 124, carrying the same name as last year's version, would encourage each state to set up a panel consisting of at least three persons, including a licensed or certified health care professional, a lawyer, and a consumer, to hear and decide any claims for damages resulting from injury or death allegedly stemming from medical practice. After hearing evidence, a panel would determine whether negligence had occurred and set appropriate damages. Periodic payments would be permissible for awards over \$100,000 and a trust fund or annuity could be established for damages over \$200,000. Limits on attorneys' fees, based on a downward scale as the amount of damages rises, would be specified. Parties to a screening panel procedure could proceed to a state court if they choose, but Senator Inouye says he is not yet certain whether the panel's findings should be admissible in subsequent legal actions. (*Malpractice Lifeline*, July 22, 1981 Vol. 6, No.7)

Note: Individual state medical societies have been developing medical malpractice legislation which deals with the particular problems inherent within their state. This proposed legislation infringes upon states' rights and for these reasons the AMA stands opposed to this bill.)

BactrimTM

(trimethoprim and sulfamethoxazole)

succeeds

Expanding its usefulness in antimicrobial therapy

—**recurrent urinary tract infections**

due to susceptible *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *P. vulgaris* and *P. morgani*

—**pyelonephritis**

due to susceptible organisms

—**acute otitis media in children**

due to susceptible *H. influenzae* or *S. pneumoniae*

—**acute exacerbations of chronic bronchitis in adults**

due to susceptible *H. influenzae* or *S. pneumoniae*

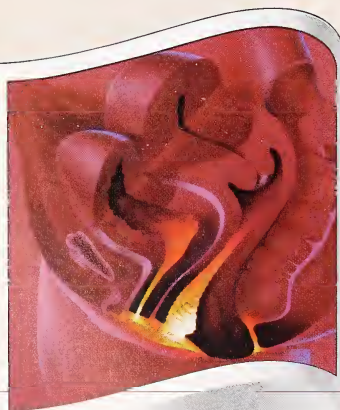
—**documented *Pneumocystis carinii* pneumonitis**

To date, Bactrim has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy

—**shigellosis**

due to susceptible *Shigella flexneri* or *S. sonnei*

Contraindicated during pregnancy at term and the nursing period, in infants less than 2 months of age, in patients hypersensitive to its components, and in those with documented megaloblastic anemia due to folate deficiency.



Bactrim™

(trimethoprim and sulfamethoxazole)

A major antimicrobial with multisystem usefulness.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age. For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term, nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus, infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily furozides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur during therapy; maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. **Pregnancy:** Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, with or without reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pain, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tremor, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, xerophthalmia with oliguria and anuria, perianteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter reduction, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age. **URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN**

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis. **Children:** Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis. **Patients with renal impairment:** Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Applied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose® packages of 100, Prescription Paks of 28 and 28, Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 40. Pediatric suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), cherry-flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 80 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), fruit-licorice flavored—bottles of 16 oz (1 pint).

ROTHENBERG PARKE ASSOCIATES

Certified Public Accountants

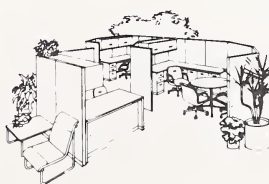
349 E. Northfield Road

Livingston, N.J. 07039

201-736-5300

Serving the New Jersey medical profession in accounting, taxation, financial planning and estate planning. Initial consultation at no charge and a complementary copy of our analysis of the new tax law with tax planning ideas.

We design offices
as if we had to
spend 8 hours a day
in them.



We believe an office is more than just a place to work. Using the finest furniture, accessories and office systems our skilled design staff creates environments.

We handle all major lines of contract furniture and accessories, as well as floor and wall coverings, window draperies and blinds. Your choice is limited only by your imagination.

FARKAS, THE INTERIOR ENVIRONMENTALISTS.

FARKAS
BUSINESS INTERIORS INC.
SIXTEEN PINE STREET
MORRISTOWN, NEW JERSEY 07960
(201) 267-1055

MONDAY-FRIDAY 9 00 A.M.-5 00 P.M. SATURDAY 10 00 A.M.-2 00 P.M.

ROCHE
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

PRN 1981-66: A Dangerous Medicaid Regulation*

Only a few short months ago "let's get the government off our backs" was a most familiar battle cry of Ronald Reagan, then campaigning for the Presidency of the United States. That this was, and is, a popular concept was proved by the almost unprecedented landslide which swept Reagan into office.

This concept was welcomed by people from all walks of life, including the medical profession, because the pendulum of health care regulations had swung too far to the left. It is now time for the pendulum to swing toward deregulation, but the message that was dispatched by the American electorate in November, 1980 apparently has not yet been received—or heeded—at the level of some state government agencies in New Jersey.

In June, 1981, several new proposed regulations were published in the New Jersey Register by Commissioner Timothy Carden, of the Department of Human Services, and applicable (initially) only to Medicaid patients.

The proposed regulation of greatest import and concern is known as PRN 1981-66. This proposed regulation, on which there will be no public hearing, states that "certain surgical procedures will have to be done by a hospital out-patient department or in an out-of-hospital setting [in order] to be reimbursed by the Medicaid program." PRN 1981-66 attempts to justify itself by stating that "approximately sixty (60) hospitals in New Jersey already participate in a same-day surgical program."

A list of the mandated "Same-Day Surgery" procedures was not appended to its publication in the New Jersey Register, but I have obtained a copy—six and one-half, closely-typed pages—and I would like to share with you only a *partial* list of those procedures:

ENT Surgery	Caldwell Luc
	Closure Oral-Antral Fistula
	Ethmoidectomy
	Open Reduction-Frontal Sinus Fracture
	Open Reduction-Zygomatic Fracture
Eye Surgery	Rhinoplasty
	Septal Reconstruction/ Septoplasty/Submucous Resection
	Stapedectomy
	Cataract (Phakoemulsification)
	Dacryocystorhinostomy
	Eye Muscle Operation (uni or bilateral)
	Iridectomy
	A-V Fistula, internal, for hemodialysis
	A-V Shunt, external, for hemodialysis
	Baker's Cyst, Excision
	Excision Branchial Cleft Cyst
	Excision Thyroglossal Cyst
	Femoral Herniorrhaphy
	Fistulectomy

General Surgery	Gynecomastia-Male Mastectomy-Bilateral
	Hemorrhoidectomy
	Hydrocelectomy
	Inguinal Herniorrhaphy
	Liver Biopsy
	Mediastinoscopy
	Orchidectomy
	Orchiopexy
	Parotidectomy
	Pilonidal Cystectomy
	Simple Mastectomy
	Sphincterotomy (no further description)
	Umbilical Herniorrhaphy
	Varicose Vein Ligation with Stripping
Gynecology	Laparoscopy—Bilateral Tubal Coagulation— D&C
	Vaginoplasty
Neurological Surgery	Neurololysis
	Rhizotomy
	Suture of Cranial and Peripheral Nerves
	Ulnar Nerve Transfer
	Amputations—toes or fingers
	Amputation Revision Large—arm or leg
	Arthrodesis
	Arthrotomy
	Bunion Operation
	Carpal Tunnel Decompression
Surgery	Hammertoes/Tenotomies/Resection of Bones
	Hand Surgery
	Hip Hardware Removal
	Metatarsal Heads Excision
	Open Reduction Fracture, with or without x-ray
	Prosthesis Replacement, finger or toe
	Sequestrectomy
	Tendon Achilles—lengthening
	Tendon repair
	Augmentation Mammoplasty with Mastopexy
	Augmentation Mammoplasty with Reconstruction (uni or bilateral)
	Chin Implant
	Dermabrasion—chemical or mechanical
	Hip Reduction or Thigh Lift
Plastic Surgery	Otoplasty (uni or bilateral)
	Reduction Mammoplasty
	Remove/Exchange Breast Prosthesis (uni or bilateral)
	Rhytidectomy—Face Lift
	Tenosynovectomy
	Wedge Resection Lip
	Prostate Biopsy
Urologic Surgery	Renal Biopsy
	Testicular Biopsy
	Varicocelelectomy

*The author Meyer L. Abrams, M.D., is a member of MSNJ's Board of Trustees. The origin of this editorial is an item from the proceedings of the Board of Trustees, July 19, 1981.

As mentioned before, this is only a *partial* list! Furthermore, the proposed regulation reads: "Surgical procedures which can be done on a hospital out-patient or out-of-hospital basis are *included but not limited to the Same-Day Procedures List*." This means, that at the Commissioner's discretion, additional procedures, possibly of greater complexity and magnitude could be added to the list of "Same-Day Surgery."

It is clear that this list of mandated "Same-Day Surgery" procedures could not possibly have been drawn up in consultation with practicing surgeons. It is a glaring example of mindless regimentation. Bureaucracy is telling physicians how and where to practice the skills for which we have been trained and licensed, while brandishing the threat of nonpayment. I greatly doubt that surgeons practicing in any of the sixty (60) hospitals cited as participating in a same-day surgical program ever have performed most—let alone all—of the procedures listed above on an out-patient basis.

While the ostensible purpose of this proposed regulation "is to prevent unnecessary hospital admission," I fear that, in practice, such a regulation would do more to prevent *necessary* hospital admissions.

While the avowed primary purpose of this regulation is economy, the proposal confesses that "exact figures are not currently available." It also states that "the economic impact on hospitals will vary." Certainly, the mandated underutilization of beds, especially in hospitals located in the inner-city, where higher numbers of Medicaid patients abound, could well destroy the ability of these hospitals to continue to exist, thus dealing a further blow to the level of medical care available to Medicaid patients. What is of equal, if not even greater, importance is that this proposal would be detrimental to proper surgical management of individual Medicaid patients.

PRN 1981-66 singles out Medicaid patients—as though they were "second-class citizens"—for this patently inferior level of care. While they may be poor, they still feel postoperative pain just like everyone else. Postoperative pain, in most of the procedures cited above, would require narcotics. Personally, I am opposed to giving out-patients

unmonitored prescriptions for narcotics. There is already enough drug abuse in this country and in New Jersey, without physicians being forced to contribute to it in this manner.

While the proposed regulation cites several exceptions whereby patients may be hospitalized for the performance of procedures on the "same-day" list, it presupposes that the attending surgeon can predict, with unerring certainty, those patients who can and those who cannot participate safely in its "Same-Day Surgery" program. It mandates the physician to "document clearly" what any complicating factors are—in advance—which would require admission. The state of our art is not so exact!

The regulation further provides that "if complications arise" during the course of his postoperative stay, and if there is a documented need to extend the patient's stay, then the patient may be admitted. Unfortunately, since the patient would, in all likelihood, be discharged almost immediately following reaction from anesthesia, the observation period, in most instances, would be inadequate to determine any impending complication. Inasmuch as home observation would be performed (or not performed at all, if the patient lives alone) by a non-professional, the developing complication could be missed, ignored or delayed until a critical or irreversible condition was created. Then only in retrospect, could one have said: "he (she) shouldn't have gone home."

Certainly our professional (malpractice) liability exposure would be significantly heightened by such a program, necessitating a further increase in professional liability premiums for all surgeons. Clearly, the added liability exposure, coupled with already ridiculously low Medicaid fees would provide an additional "dis-incentive" for physicians to participate in the Medicaid program.

Finally, the Medical Society of New Jersey, representing most of the practicing physicians in the State, always has stood ready to consult, advise, and lend its expertise in medical care matters to the Governor, members of the State Legislature, the Commissioners and their Deputies. We stand ready now—all they need to do is ask.

Meyer L. Abrams, M.D.

Teenage Nutrition

Adolescence represents a time of dynamic change involving both biological and emotional growth. Fifty percent of adult weight and 20 percent of linear growth are achieved during adolescence. Nutrition and healthful food habits play a major role during this developmental process in determining whether the adolescent is able to reach full growth potential and maintain good health throughout adulthood.

Concerns over appearance, academic and athletic performance and peer pressure influence food choices. Teenagers tend to eat more meals away from home, skip meals and snack more often. The Ten-State Nutrition Survey revealed that among all age groups, adolescents between the ages of 10 and 16 had the highest prevalence of unsatisfactory nutritional status.¹

Both males and females are equally vulnerable to special adolescent nutrient needs and potential deficiencies. Nutritional imbalances in this age group lead to common problems including nutritional anemias, obesity and sports-related injuries secondary to dehydration and exhaustion. A

dietary history can be a significant indicator of adequate nutrient intake over time when screening teenagers with potential health problems.

Most iron deficiency in childhood occurs during two periods of most rapid growth: infancy and adolescence. Teens are susceptible to iron deficiency due to dramatic increases in muscle tissue and red cell mass. Adolescent girls are affected more often than boys due to poor iron intake and menstrual blood losses. Iron deficiency may be suspected in an adolescent by a dietary history reflecting inadequate iron intake, by low hemoglobin or hematocrit levels, transferrin saturation, erythrocyte protoporphyrin concentration and plasma ferritin levels.

Obesity is one of the most common nutritional and general health problems during adolescence. Obese adolescents experience a wide range of psychological and social difficulties including defective body image, decreased self-esteem, depression and feelings of rejection.

It is difficult to gauge obesity based on body weight alone in teenagers. The use of skinfold calipers to determine skinfold thickness over the triceps and subcapular regions

can be an excellent indicator of the degree of overall adiposity. This method is easy to use.^{2,3}

Recent reports suggest that behavioral techniques (combined with nutrition education and prescribed physical exercise) are most likely to be successful methods for treating obese teenagers.⁴ Specific techniques of problem solving and realistic goal setting provide a sense of responsibility and accomplishment. Family involvement is also a key for success. Followup with intensive support and counseling from a physician or nutritionist trained in behavioral techniques promotes more positive long-term results. Inappropriate methods of treatment, such as severe caloric restriction or avoidance of favorite foods, result in feelings of deprivation, frustration and failure.

Teenagers themselves, however, often attempt self-imposed fad diets as a means of weight control. These diets frequently take the form of a high protein, low carbohydrate intake with little emphasis placed on nutritional balance or modification of poor food habits. At any given time, as many as 30 percent of adolescent girls are on such diets.⁵ Therefore, appropriate intervention and education is highly indicated.

Adolescents involved in competitive sports also face potential nutritional risks if they believe the abundant myths concerning nutrition and athletic performance. There is no evidence that an increased intake of food supplements or nutrients has any specific benefits affecting athletic performance. In some cases harmful results may be produced. Protein supplements are popular due to the misconception that increased protein intake results in increased muscle mass. Athletes should be taught that daily diets appropriately selected from basic food groups will provide an adequate intake of all nutrients, and that vigorous training requires only increased total caloric intake.

Severe fluid and food restrictions and induced sweat losses are also dangerous methods practiced by some young athletes to make a lower weight classification in sports such as wrestling. This regimen can result in loss of lean body tissue, electrolyte imbalances and dehydration with a negative impact on athletic performance.⁶ A far more suitable program for weight and nutritional control in athletes has been outlined by Tipton⁷ and by Smith⁸.

In general, health promotion during adolescence involves establishing food habits that lower the risks of degenerative diseases. About 25 percent of the calories that adolescents eat are from low-nutrient-density foods including desserts, sugar

and salt-laden snack foods (soda, candy, potato chips), fats and oils.⁹ Since many teens eat more snacks "on the run" and more meals away from home, "fast food" items, which are frequently high in calories, sugar, salt and fats, are often popular. Although teenagers should not be convinced to eliminate these foods, they should be encouraged not to rely on these sources as the mainstay of their total diet.

The United States Department of Agriculture has developed "Dietary Guidelines for Americans" for the sole purpose of promoting health through good nutrition.⁹ These guidelines encourage eating a variety of wholesome foods daily with an adequate intake of starch and fiber. Fat, particularly saturated fat, refined sugar and sodium are de-emphasized, alcohol is to be avoided. Guidelines for maintaining or achieving ideal weight also are outlined.

Although good nutrition combined with physical exercise promote long-term good health, this does not always interest the teenage audience. A focus on more short-term results is of greater appeal to adolescents. The benefits of good appearance, physical and mental endurance, and positive peer pressure provide more attractive highlights.

Avrum L. Katcher, M.D.
Melanie Rhoades, M.D.

References

- ¹Ten State Nutrition Survey 1968-1970. U.S. Department of Health, Education and Welfare. Publication No. (HSM) 72-8134.
- ²Wilmore JH: *Athletic Training and Physical Fitness*. Boston, Allyn and Bacon, 1977.
- ³Lohman TG et al: Predictors of lean body mass in young boys from skinfold thickness and body weight. *Human Biology* 47:245-262, 1975.
- ⁴Story M, Schollosser, P: Food Behaviors and Weight Problems in Adolescents. Kansas Bureau of Maternal and Child Health, 1980.
- ⁵Dwyer J: Nutritional risk factors in adolescence. From the presentation summaries of "Teenage Nutrition: Threat or Threshold to a Healthy Adult Life?" Nutley, NJ, Hoffmann-La Roche, 1980.
- ⁶McArdle WD, Katch, FI, Katch, VL: *Exercise Physiology, Energy, Nutrition and Human Performance*. Philadelphia, Lea and Febiger, 1981.
- ⁷Tcheng TK, Tipton CM: Iowa wrestling study: Anthropometric measurements and the prediction of "minimal body weight for high school wrestlers." *Med Sci Sports*, 5: 1-10, 1973.
- ⁸Smith NJ: Nutrition and athletic performance. *Resident and Staff Physician*, pp. 30-38, April 1981.
- ⁹Nutrition and Your Health: Dietary Guidelines for Americans. Home and Garden Bulletin No. 232. U.S. Department of Agriculture, 1980.

Florio vs. Kean

In this issue of *The Journal* (p. 727), the two candidates for Governor of New Jersey participate in a seven-round debate. They were asked to comment on their individual thoughts, perceptions and attitudes on important health care matters in our State.

Each reader of this *Journal* should pay close attention to the responses of these candidates, for their words and between-the-lines implications tell a good deal about the probable course of events from the health viewpoint in the next four years. To this writer, the questions relating to the next Commissioner of Health and membership on the State Board of Medical Examiners are keystones.

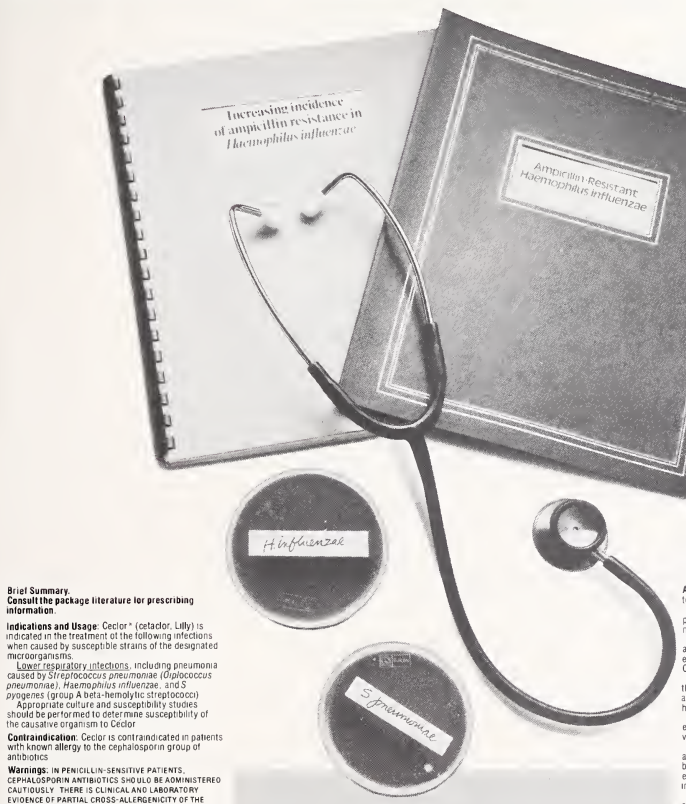
In World War II, ships in convoy in enemy infested waters often were instructed to take "evasive action" to avoid the

potential of a direct hit by a torpedo launched from a submarine. It appears that the answers of the Democrat candidate for Governor, Florio, largely represent "evasive action" and rarely touch the heart of the question. One can hardly sympathize with the failure to respond to the question on the candidate's platform. The Republican candidate, Kean, is more direct and, to some degree, reflects the policies and attitudes of the national administration.

Each reader should evaluate and vote for the candidate of his choice. As all physicians and their families should know, the philosophy and knowledge of the occupant of the Governor's chair has a large effect on day-to-day health matters of vital importance to us all.

A.K.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Cecilor® (cefadroxil, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Upper respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (diplococcus pneumoniae), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococcus). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cecilor.

Contraindication: Cecilor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLACTIC AFTER PARALLEL USE).

Antibiotics, including Cecilor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefadroxil occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Friedling use of cefadroxil may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporins. In hemologic studies or in transfusion cross-matching procedures when antigen-antibody tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cecilor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cecilor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinette® tablets but not with the "Tap" (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receive up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cecilor.^{1,6}

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococcus), or multiple organisms achieved a satisfactory clinical response with Cecilor.⁷

Cecilor®

Cefadroxil

Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefadroxil therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Clinical Relationship Uncertain—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cecilor® (cefadroxil) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References:

1. Antimicrob. Agents Chemother. 8:91, 1975.
2. Antimicrob. Agents Chemother. 17:470, 1977.
3. Antimicrob. Agents Chemother. 17:564, 1976.
4. Antimicrob. Agents Chemother. 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), 11:580, Washington, D.C.: American Society for Microbiology, 1976.
6. Antimicrob. Agents Chemother. 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 467, New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from:
Eli Lilly and Company
Indianapolis, Indiana 46205
Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

100061

DESCRIPTION: Methyltestosterone is 17β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male, 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecostasia may occur rarely. FBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecostasia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., J. B. Sipahoglu, M.D., *Hormones for Improved Sexuality in the Male and the Female Climacteric, Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android[®] /5^{Buccal} /10^{Oral} /25^{Oral}
mg. mg. mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric /eunuchoidism, eunuchism /post-pubertal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Florio and Kean Respond to Health Care Issues



James J. Florio
Congressman, 1st Dist., NJ



Thomas H. Kean

(The following is the complete text of responses to seven questions submitted by JEMPAC to each of the candidates.)

(1) What do you perceive as the major health issue(s) facing the citizenry of New Jersey and how do you propose to meet these challenges?

Government must look at health issues from two inseparable points of view. Prevention and cure remain paramount, to be sure; but almost as important, in our complex society is the question of the organization and financing of an effective health delivery system. You, as physicians, will continue to develop the means to practice good medicine. We, as government, will attempt to perfect a vehicle which will ensure that all of the citizens have good access to medical care when needed, including the ability to be able to afford that care.

Our predominant health issue is the successful integration of these parallel efforts.

My vision of good government is not as a regulator or repressor of dedicated professionals. As partners with you in the health care system, I will seek your counsel and guidance through your established advisory committees.

My concern is to assure the citizens of New Jersey the highest quality of health care at the lowest cost possible, for now and in the future. Some areas of concern that need to be addressed are hospital regulations, cancer research and outreach programs, mental health, urban hospital solvency, nursing home availability, resident nursing home safety/security, family rejection and control, geriatric medicine, the nursing shortage, Medicare payments' funding and planning procedures and education by state home-care personnel.

These concerns will be addressed by first declaring a moratorium on new regulations within the State Department of Health, and then reviewing the overregulation and currently consistently changing methodology, in order to eliminate unnecessary and burdensome regulations and to develop some consistency of programs. When there is duplication of regulation, agencies will either eliminate or combine the responsibility and authority. The pressing needs in New Jersey should be viewed more as a participatory process by the providers, conformers, insurers and the public.

(2) What are your thoughts on the current Diagnosis Related Group (DRG) Program as a cost-effective program and its relationship to good medical care, and what, if any, changes do you perceive during your term of office?

I would caution that we not "take sides" too early on this very complex issue. Within a year or two we will be able to make very informed decisions and evaluations of the entire DRG system. Certainly there have been some early DRG experiences which have outraged some and amused others. It is my understanding that the system is undergoing steady revision and correction as these items come to light.

Not everyone is aware that several inner city hospitals, whose survival I consider mandatory, have been pulled back from the brink of financial disaster as the result of the DRG system and the other financial reimbursement mechanisms established by Chapter 83. There has also been little publicity about the fact that many other states, who perceive New

The DRG experiment is a paramount concern. It is an experiment and is viewed as an experiment. It may be containing costs, but must also be examined to determine whether it is cost effective in terms of quality of care, growth of new programs or the status of overall health care delivery. These issues must be reviewed on an ongoing basis. The experiment has a termination date at the end of 1983. At that time the DRG system should be reviewed to determine whether it has been effective and what, if any, modifications are necessary.

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

Jersey as being in the forefront of health care planning, have been studying our system diligently and taking initial steps toward the implementation of similar systems.

New Jersey's system of health care, due a large part to the excellent physicians we have in this State, has been successful with government playing a strong role. However, I can assure you that government, during my administration, will never intrude into the physician's office to tell you how to practice your science and art. Together, we will continue to evolve a system which will permit you to serve society and which will permit society to be able to afford those services.

(3) MSNJ has proposed that members of the State Board of Medical Examiners serve no more than 2 consecutive 3-year terms, and to preserve continuity the terms of all members should be staggered. What is your position on this matter?

You have offered two sound suggestions which might well apply to many regulatory bodies, including the State Board of Medical Examiners. Limitations on repetitive service by participants is in concert with similar limitations fixed by law on the tenures of governors and presidents. The staggering of terms to preserve continuity is obviously constructive. But most important of all, as I see it, is the selection of appointees who are truly representative and respected. The State Board of Medical Examiners of New Jersey has been identified as one of the most active and effective in the Nation. Of this your membership can be proud. I intend to work with you to maintain this effectiveness during my tenure as Governor.

I agree with this proposal. It will allow for greater continuity, better administration and more effective interpretation of rules and regulations.

(4) Less federal funding and regulations could prompt state governments to assume responsibilities previously administered by the Federal Government. What do you anticipate as reduction or expansion of regulations and funding in the area of health care in New Jersey, i.e., HSAs, Medicaid, Medical Assistance, Health Coordinating Council?

Less federal funding has already begun to shift more responsibility to the State, both in terms of direct services and in terms of planning. The Governor must be prepared to meet these challenges. I have already arranged to meet with leaders of the health care system to determine what changes will be necessary in response to the federal initiatives. There are statewide voluntary committees already organized and meeting to discuss ways to streamline the current regulatory system to meet the expected funding cuts.

Medicaid was treated rather well in Congress as compared to the first reports. The American Public Welfare Association submitted a report to the federal Health Care Financing Administration (Department of Health and Human Service—"HSS") listing barriers to efficient Medicaid program operation. The report commented on 49 different barriers to efficient operation of the Medicaid program. The administration has taken this as a good example of how states can streamline their programs and save the federal government hundreds of millions of dollars in health care costs.

The Congress has approved greater flexibility in the Medicaid program without cutting much. Instead of capping the costs, the new regulations will fund Medicaid costs of the states, less three percent. If states have instituted certain cost-saving procedures (such as hospital rate setting as New Jersey has) only two percent will be subtracted from the federal share.

Some speculated that N.J. would lose up to \$80 million with the Medicaid revisions. Now, it appears that the "loss" (better understood as a diminished expectation for reimbursement) will only be \$9 million. This figure may even be lower if the state is able to take advantage of other cost-saving procedures.

In the past few years health planning has been funded primarily by the Federal Government. However, the Reagan administration has announced its intention to phase out federal support of local health planning, but a workable model must be produced lest the state have to pick up the cost where the Federal Government is leaving off.

The key process with which the state controls health planning is through certificate of need (CON). In 1980 there were 400 applications for certificate of need and federal grants which were reviewed first by one of five regional

HSA's and then the State Department of Health. In most cases these reviews were made by four separate committees, two at the regional level and one at the state level.

It is recommended that when federal funding for the regional HSA's is eliminated that these HSA's be phased out and a review process rest at the state level. However, a board established with regional representation should have ultimate responsibility for the review process. Additionally, the minimum capital expenditure for a reviewable item can be raised from the current \$150,000 to a more realistic level that would be consistent with current Congressional proposals with respect to health planning. Funding for the review process at the state level should not increase but any increase in the cost of review should be obtained by an increase in the certificate-of-need application fee.

(5) What qualities and qualifications will you be seeking for the appointment of a commissioner of health?

The Commissioner of Health will be someone who has both the ability and the philosophic base to implement the general health care policy operating in the State of New Jersey, and as modified during my administration. He or she will be a doctor of medicine, as required by law, and someone with a profound understanding of the complexities inherent in a democratic system which must function effectively despite shifting economic and social constraints. The commissioner will put the health needs of the citizens of New Jersey first, the economic viability of the system second and political loyalty to an administration somewhere toward the rear.

There is a need for a man or woman in the cabinet to clearly articulate the Health Policy for New Jersey. That new appointment will be one of the most important of my administration. I will seek the advice of professional bodies, the New Jersey Hospital Association and others in seeking an individual with experience in health care and administration. I would like to obtain someone with experience in the New Jersey health care system.

(6) The continuing high monetary awards granted by juries concerned with automobile, professional and product liabilities has prompted the suggestion for tort reform. What, if any, reforms might you be recommending for study for change?

Extraordinary increases in rates in each of these areas is the cause of great concern. We must look carefully at the problem to see what solutions are available.

In the area where I have direct experience, product liability insurance, insurance rates have made product liability insurance virtually unaffordable for many manufacturers. Manufacturers go without coverage, putting their businesses at risk, or simply pay rates which they cannot afford.

After looking at this problem, my Subcommittee reported a bill, which was approved by the House in late July, which will help address this problem. First, it will allow manufacturers to form their own risk retention groups to self-insure. Second, it will allow manufacturers to purchase product liability insurance collectively. Both options will limit the incredible increases in product liability insurance which manufacturers have faced. States can now take further steps to encourage these groups.

We must act to insure that we have a sensible system for protecting both the providers of service and the recipients. Only after a careful examination of each area can we take all the steps that are necessary to make the needed changes.

(7) In 200 words or less what is the essence of your platform?

As we went to press Congressman Florio's platform had not been completed.

The threshold for automobile liability must be raised. The current level of \$200 is totally unrealistic. I have advocated an increase to the \$1,000 range. Further, a review of liability law reforms in other jurisdictions may prove useful in New Jersey.

(7) In 200 words or less what is the essence of your platform?

New Jersey faces a series of pressing needs. Crime has been increasing for eight years at a rapid rate, and recent increases in violent crimes are startling. I have proposed a series of steps, including the death penalty, bail and plea bargaining reform, and a tougher attitude toward career criminals and repeat juvenile offenders, to solve this problem.

Our toxic waste problems are solvable. Congressional committees have investigated the problem and found that our problems stem from poor administration and lack of law enforcement, not a lack of funding. I will move vigorously to put illegal dumpers in jail and aggressively investigate the location of dump sites in New Jersey.

The most important part of my platform is a commitment to economic growth. We will never have sufficient funds for education, transportation and other worthy programs, unless we stop the exodus of jobs that has been occurring for eight years. I believe we must cut taxes and pursue an active program of regulatory reform if we are to restore New Jersey to a position of economic health. The Reagan tax cuts will keep billions of dollars in New Jersey that otherwise would have been paid to Washington in taxes. We must do everything possible to permit that money to be invested and utilized in our state.

At 3:45 PM mild mannered Debbie Catullo made a harried doctor smile.

Debbie is part of our special Blue Shield professional relations staff. Debbie and her colleagues specialize in answering physicians' questions. You can depend on our professional relations staff for quick answers to your questions regarding claims, billing information, and contract interpretation.

In addition, professional relations staff members handle the enrollment of new participating physicians, and the training of medical assistants.

So, next time you run into a Blue Shield related problem, call on us for the answer.



*"It's our job to
make things simple."*



Blue Shield of New Jersey

Neuroendocrine Diagnostic Tests in Psychiatry

IRL EXTEIN, M.D., A.L.C. POTTASH, M.D.,
MARK S. GOLD, M.D., Summit*

Studies by the authors and others indicate that abnormalities on the dexamethasone suppression test and thyrotropin-releasing hormone test can help distinguish major depressive disorder from other forms of depression, and mania from schizophrenia. These results suggest that the tests may aid in treatment planning, particularly in choice of pharmacotherapy.

Psychiatrists long have searched for measurable biological abnormalities that would reliably identify the major psychiatric disorders and aid in differential diagnosis and choice of treatment. The development in the past 25 years of effective and specific pharmacotherapies for major depression, manic-depressive illness, and schizophrenia has underlined the importance of diagnosing these disorders accurately.¹ The efficacy of tricyclics and monoamine oxidase inhibitors in depression, lithium in manic-depression and antipsychotics (neuroleptics) in schizophrenia, as well as the demonstration of a strong genetic component in the etiology of affective disorders and schizophrenia have given credibility to the working assumption that neurobiological abnormalities underlie many of the major psychiatric disorders. Despite the advances of clinical nosology embodied in the new Diagnostic and Statistical Manual of the American Psychiatric Association, the DSM III,² the use of biological markers may define more clearly homogeneous groups of psychiatric patients and guide choice of treatment. For example, the term depression can be applied to a spectrum of clinical syndromes that may appear similar but which may respond differently to antidepressant medication.^{1,3} In this article we will review two neuroendocrine tests—the dexamethasone suppression test (DST)^{4,5} and the thyrotropin-releasing hormone (TRH) test⁶⁻¹²—with which we have extensive experience and which may confirm clinical diagnosis and aid choice of pharma-

cotherapy in psychiatry.

Several biological measures have been proposed as biological markers for psychiatric disorders, particularly for affective disorders.³ Changes in levels of metabolites of central monoaminergic neurotransmitters in the cerebrospinal fluid and urine of depressed patients have been reported. Changes in electroencephalographic parameters of sleep in depressed patients have been reported as well. The approach that has shown the most promise for routine clinical use, and the approach which our group has pursued the most actively, is what has been called the neuroendocrine strategy.

The vegetative symptoms of depression, including disturbances of sleep, appetite, weight, and libido—the hypothalamic symptoms of depression—long have suggested neuroendocrine abnormalities in depression. A variety of abnormalities in neuroendocrine function and response to provocative stimulation have been reported in patients with major depression.⁴ Two tests which have been extensively

*Dr. Extein is Director of Research and Training, Fair Oaks Hospital, Summit, NJ, and Collaborative Scientist, Clinical Psychobiology Branch, National Institute of Mental Health, Bethesda, Md. Dr. Pottash is Associate Medical Director, Fair Oaks Hospital, and Lecturer, Department of Psychiatry, Yale University School of Medicine, New Haven, Conn., where Dr. Gold is also Lecturer. In addition Dr. Gold is Director of Research, Psychiatric Diagnostic Laboratories of America, Summit, NJ. Correspondence may be addressed to Dr. Extein, Fair Oaks Hospital, 19 Prospect Street, Summit, NJ 07901

"Approximately 50 percent of all patients with a clinical diagnosis of major depression fail to suppress on a standard DST."

studied and show reliable or reproducible changes in patients with affective disorders are the DST and the TRH tests. Both are standard endocrine tests which have been used for years in the diagnosis of diseases of the hypothalamic-pituitary-adrenal (HPA) axis and hypothalamic-pituitary-thyroid (HPT) axis, respectively.¹³ Only more recently have these tests been applied to confirming psychiatric diagnosis and demonstrating response to treatment.

THE DEXAMETHOSONE SUPPRESSION TEST (DST)

The DST begins with administration of one mg of dexamethasone orally at midnight.^{4,5} The patient will experience no subjective effects from this test. Small samples of blood are obtained by venipuncture at the time of dexamethasone administration and then at 8 am, 12 noon, 4 pm, and 12 mn the next day for determination of serum cortisol in duplicate by radioimmunoassay (RIA). The test is abnormal (i.e., shows failure to suppress cortisol production) if the cortisol level is ≥ 5.0 ug/dl at any of the time points after dexamethasone administration. Approximately 50 percent of all patients with a clinical diagnosis of major depression fail to suppress on a standard DST. In addition, many of these patients have hypercortisol secretion and some have a loss of the normal diurnal pattern of cortisol secretion. Thus we see that while most patients with major depression do not have true Cushing's syndrome, about half of them have a Cushing's-like biochemical profile. The failure to suppress on the DST is extremely rare in other psychiatric disorders, with a false-positive rate of less than five percent. The diagnostic confidence level of an abnormal DST in the diagnosis of major depression in a mixed population of psychiatric patients is approximately 95 percent. This means that in such a population the failure to suppress on the DST identified a patient with a major depression approximately 95 percent of the time.

THE THYROTROPIN-RELEASING HORMONE (TRH) TEST

The TRH test consists of measurement of the secretion by the pituitary of thyroid-stimulating hormone (TSH) in response to intravenous administration of the hypothalamic hormone TRH.⁶⁻¹² An indwelling venous catheter is placed in patients who are at bedrest at 8 am after an overnight fast. At 9 am 500 ug of synthetic TRH are administered over 30 seconds through the catheter. The patient experiences only mild, transient autonomic symptoms such as the urge to urinate. Before and 15, 30, 60, and 90 minutes after TRH administration small samples of blood are obtained via the catheter for measurement of serum TSH in duplicate by RIA. The maximum TSH response, or Δ TSH, is determined for each patient by subtracting the baseline TSH from the peak TSH level after TRH infusion. Growth hormone (GH)

Table 1

The TRH test in the differential diagnosis of depression

	N	Δ TSH in uIU/ml	
		>7.0	≤ 7.0
Normal Controls	20	20	0
Non-Major Depressions	40	36	4
Major Depression Primary Unipolar Subtype	105	45	60*

*different from non-major depressions and controls, $p \leq .01$ by Chi-Square test.

also may be measured after TRH infusion, since patients with major depressions may have a positive GH response to TRH not found in other psychiatric patients or normal controls.⁹

Patients with major depression, unipolar type are depressed patients with endogenous features without history of mania. They are important to identify because they are likely to respond to tricyclic antidepressants. Patients with major unipolar depressions tend to have a blunted TSH response to TRH, compared to patients with non-major depressions of the kind seen in adjustment reactions, grief reactions, or personality disorders, who tend to have normal TSH response to TRH.⁶⁻¹⁰ Several factors can decrease the TSH response to TRH and they must be taken into account in interpreting TRH test results in depression.¹³ These include hyperthyroidism, corticosteroids, alcoholism, some drugs, and age over 60 in males. Factors which can augment the TSH response to TRH include hypothyroidism and lithium therapy. The mean Δ TSH in 20 normal volunteer subjects tested by our laboratory was 13.4 ± 1.0 uIU/ml.

We have found the definition of Δ TSH ≤ 7.0 uIU/ml as a blunted TSH response to TRH useful in discriminating subgroups of depression.¹⁰ In one study we administered the TRH test to 145 consecutive euthyroid, non-alcoholic patients who met Research Diagnostic Criteria (RDC) for major depression, primary unipolar subtype, or non-major depressions (minor or intermittent depression).¹⁴ The patients with non-major depressions all met DSM III Criteria for dysthymic disorder, adjustment reaction or personality disorder.² The mean Δ TSH of $7.3 \pm .5$ uIU/ml in the 105 unipolar patients was significantly lower ($p \leq .01$ by t-test) than that of $10.9 \pm .7$ uIU/ml in the 40 patients with non-major depressions. Sixty-five of the unipolar depressed patients, but only four of the non-major depressed patients and none of the controls showed a Δ TSH ≤ 7.0 uIU/ml (see Table 1). These intergroup differences were significant at the $p \leq .01$ level by chi-square test. If a Δ TSH ≤ 7.0 uIU/ml is used as a diagnostic test to identify patients with a clinical diagnosis of major unipolar depression in this group of patients and controls, the sensitivity is 56 percent, the specificity is 93 percent, and the diagnostic confidence level is 91 percent. Our preliminary results with bipolar depressed patients, who unlike unipolar depressed patients have a history of mania, suggest that these patients have a normal or augmented TSH response to TRH.^{8,9}

We also have found that manic patients tend to have a blunted TSH response to TRH.^{11,12} Patients with schizophrenic psychosis tend to have a normal response. We

Table 2

The TRH test in the differential diagnosis of mania and schizophrenia

	N	Δ TDH in uIU/ml	
		>7.0	≤7.0
Mania	25	10	15*
Schizophrenia	33	23	10

*different from schizophrenia, $p \leq .05$ by Chi-Square test.

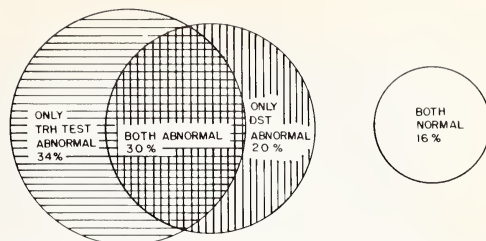
administered the TRH test to 52 consecutive euthyroid, non-alcoholic admissions who met RD criteria for mania or schizophrenia, undifferentiated or paranoid subtype. The mean Δ TSH of $6.5 \pm .6$ uIU/ml in the 25 manic patients was lower than that of $9.6 \pm .8$ uIU/ml in the 33 schizophrenic patients, all of whom were actively psychotic ($p \leq .01$ by *t*-test). Using the criterion of Δ TSH ≤ 7.0 uIU/ml as blunted, 60 percent of the manics but only 30 percent of the schizophrenic patients showed a blunted TSH response to TRH (see Table 2). This difference was significant at the $p \leq .05$ level by chi-square test.

CLINICAL USES

Both the DST and the TRH tests have been proposed as useful tests in identifying patients with major depressions.^{4,5,8-10,15,16} Major depressions, which sometimes are referred to as endogenous depressions, are characterized by vegetative features such as sleep and appetite disturbance and tend to respond to antidepressant medications or electroconvulsive therapy (ECT).^{1,3} It can at times be difficult on clinical grounds alone to distinguish major depressions from other syndromes with depressed mood which do not tend to respond to antidepressant medications. These other depressive syndromes include, in DSM III terms, dysthymic disorder, adjustment reactions, and personality disorders. These used to be called reactive or neurotic depressions in older nomenclature.

There is evidence that the DST and TRH tests also can help distinguish major depression, primary subtype, from similar appearing depressions that may be secondary to other conditions, including medical illnesses. In ambiguous cases we find that abnormal DST and TRH tests can aid in the decision as to whether a major depression with biological abnormalities exists, and hence whether antidepressant medication may be useful. In a rigorously selected group of patients with major depression, antidepressant medication can lead to remission in more than 75 percent of the cases, particularly when adequate doses are used and blood levels of the antidepressant medication are monitored.¹ Therefore, tests which can help identify these medication-responsive depressed patients are of immense value.

If we use the DST as a diagnostic test for major depression, failure to suppress identifies about 50 percent of the major depressions. This test has few false-positives but about 50 percent false-negatives.⁵ A positive finding is extremely useful, but a negative finding is less significant. In our hands, using the TRH test as a diagnostic test for major unipolar depression gives somewhat fewer false-negatives but slightly more false-positives than does the DST. In a study of 50 consecutive euthyroid, non-alcoholic patients who had both a DST and a TRH test, 50 percent failed to suppress on the



Figure—Relationship of TRH test and dexamethasone suppression test (DST) abnormalities in 50 patients with unipolar depression.

DST and 64 percent had a blunted TSH response to TRH.¹⁶ There was no relationship between these two abnormalities by chi-square test. Thirty-four percent had an abnormality on the TRH test only, 20 percent on the DST only, 30 percent on both, and 16 percent on neither (see Figure). Thus each of the two tests identifies patients not recognized by the other, and the two tests seem necessary and complementary in the neuroendocrine evaluation of the depressed patient.

Distinguishing between unipolar and bipolar depression also can be difficult on clinical grounds alone. Bipolar depression is defined as a major depression in a patient with a history of mania. Such a patient is said to have manic-depressive illness, or the newer term, bipolar affective disorder. Such a patient is likely to benefit from treatment with lithium carbonate both for the acute depression and as prophylaxis against recurrent depressive and manic episodes.¹ Bipolar depressed patients can be missed if they have histories of mild mania—called hypomania—only, or if they are in their first few episodes of affective illness. A biological test that could identify bipolar patients would be extremely useful. The DST does not differentiate unipolar from bipolar depression.^{4,5} As stated above, preliminary reports from our group and others suggest that the TRH test may help distinguish unipolar from bipolar depression,^{8,9} though further research is needed to clarify this point.¹⁷

The TRH test also seems to be helpful in distinguishing manic patients from actively psychotic schizophrenic patients.^{11,12} Manic-depressive patients in the manic state can display paranoia and other psychotic symptoms that are similar to those seen in schizophrenic patients.¹¹ The ability to differentiate these two disorders is crucial for several reasons, including the more optimistic prognosis of affective illness, the greater therapeutic effect of lithium in bipolar illness¹ and of anti-psychotic medication in schizophrenia, and the risk of tardive dyskinesia in misdiagnosed bipolar patients treated for many years with antipsychotic medication.

We have focused on the use of the DST and the TRH tests in making psychiatric diagnoses. An added clinical bonus from the routine clinical use of these tests is the ability to diagnose primary endocrine diseases which may be contributing to the emotional disturbance. The DST can detect previously undiagnosed Cushing's syndrome, which is known to cause profound mood changes.¹³ The TRH test can confirm or diagnose previously undiagnosed thyroid diseases.^{13,18} In particular, marked elevations of the TSH response to TRH (Δ TSH ≥ 30 uIU/ml) suggest hypothyroidism, which in the early stages cannot be detected by the usual signs and symptoms of hypothyroidism or by

T3- uptake, T4, or baseline TSH, and which may be contributing to anergia and depression.¹⁸

Depressed patients who fail to suppress on the DST do not usually have the signs or symptoms of Cushing's syndrome. Those affectively ill patients who have an abnormal TSH response to TRH usually do not have the signs and symptoms of thyroid disease. The abnormalities in these two tests in patients with affective disorder probably reflect changes in the central neurotransmitters which regulate both mood and hypothalamic function.¹³ These include norepinephrine, dopamine, serotonin, and possibly TRH itself. In a sense the DST and the TRH tests are "windows into the brain" which enable us to see neurobiological changes in the brain in patients with affective illness which otherwise could not be detected safely and easily.

Abnormalities in the DST and the TRH tests in depressed patients are now known to normalize with clinical and neurobiological improvement during the course of treatment.^{19,21} Thus, by repeating these tests during the course of treatment, the clinician can obtain critical prognostic information about when the neurobiological abnormalities of depression are in remission. This information may help determine when antidepressant medication or ECT is no longer needed, and when continued or different treatment is needed. This use for the DST and TRH test in confirming successful treatment is particularly important in psychiatry where efficacy is questioned and has been difficult to demonstrate by other than a clinical interview. Several well-controlled studies have suggested that patients who have the persistence of DST or TRH test abnormalities after treatment have a much higher probability of relapse, regardless of clinical appearance or outcome up to that time.^{7,20} The prognostic value of the DST and TRH test in depression is an exciting area for further research.

SUMMARY

The dexamethasone suppression test (DST) and the thyrotropin-releasing hormone (TRH) test are standard endocrine tests. Recent studies show that both tests are useful in psychiatry in differentiating major depressive disorders from the many other psychiatric and medical conditions that can cause depressed mood. In major unipolar depression a blunted TSH response to infusion of 500 ug of TRH is present in approximately 60 percent of the patients and failure to suppress cortisol secretion after oral administration of one mg of dexamethasone is present in approximately 50 percent. The TRH test also may be helpful in differentiating unipolar from bipolar depression. When both tests are used approximately 85 percent of patients with the clinical diagnosis of major unipolar depression can be identified. The TSH response to TRH is blunted in mania and hence may aid in differentiating mania from schizophrenia.

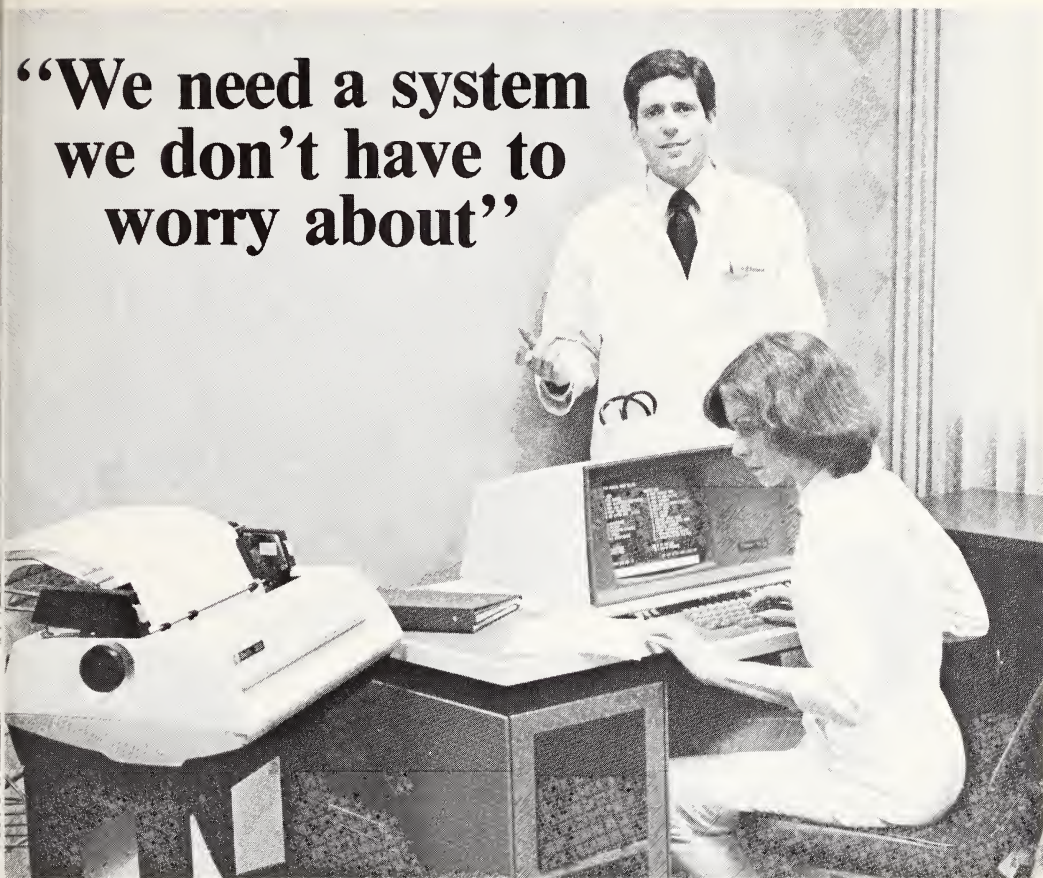
These two tests may help the clinician to identify patients with medication-responsive psychiatric syndromes, including patients with major depressions, who are likely to benefit from antidepressants, and manic-depressive patients, who are likely to benefit from lithium. Normalization of these tests during the course of treatment appears to reflect normalization of the underlying biochemical changes in the brain and suggests that the active disease process is in remission. These data may aid the clinician in knowing when to change or stop treatment and in establishing prognosis.

The DST and TRH test may become part of a nosology for the diagnosis of affective illness in the 1980's that includes both descriptive and chemical data, analogous to the approach used in internal medicine in the diagnosis of autoimmune diseases.

REFERENCES

1. Goodwin FK: Drug treatment of affective disorders: General principles, in Jarvik ME (ed): *Psychopharmacology in the Practice of Medicine*. New York, Appleton-Century-Crofts, 1977, pp. 241-253.
2. Spitzer RL: *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. Washington, DC, The American Psychiatric Association, 1980.
3. Goodwin FK, Extein I: the biological basis of affective disorders, in Cancro R, Shapiro L, Kesselman M, (eds): *Progress in the Functional Psychoses*. New York, Spectrum Publications, 1979, pp 129-152.
4. Sachar EJ: Evidence for neuroendocrine abnormalities in the major mental illnesses, in Freedman DX (ed): *Biology of the Major Psychoses*. New York, Raven Press, 1975, pp 347-358.
5. Carroll BJ, Curtiss GC, Mendels J: Neuroendocrine regulation in depression. *Arch Gen Psychiatry* 33: 1039-1058, 1976.
6. Prange AJ Jr., Wilson IC, Lara PP, Alltop LB, and Breese BR: Effects of thyrotropin-releasing hormone in depression. *Lancet* 2: 999-1002, 1972.
7. Kirkegaard C, Bjorun N, Cohn D, Faber J, Lauridsen OB, and Nerup J: Studies on the influence of biogenic amines and psychoactive drugs on the prognostic value of the TRH stimulation test in endogenous depression. *Psychoneuroendocrinology* 2: 131-136, 1977.
8. Gold MS, Pottash ALC, Davies RK, Ryan N, Sweeney DR, and Martin DM: Distinguishing unipolar and bipolar depression by thyrotropin release test. *Lancet* 2: 411-413, 1979.
9. Gold MS, Pottash ALC, Ryan N, Sweeney DR, Davies RK, and Martin DM: TRH-induced TSH response in unipolar, bipolar, and secondary depressions: Possible utility in clinical assessment and differential diagnosis. *Psychoneuroendocrinology* 5: 147-155, 1980.
10. Extein I, Pottash ALC, and Gold MS: TRH test in depression. *N Engl J Med* 302: 923-924, 1980.
11. Extein I, Pottash ALC, Gold MS and Martin DM: Differentiating mania from schizophrenia by the TRH test. *Am J Psychiat* 137: 981-982, 1980.
12. Extein I, Pottash ACL, and Gold MS: Decreased TSH response to TRH in mania compared to schizophrenia. *Soc Neurosci Abstr* 6: 759, 1980.
13. Martin JP, Reichlin S, and Brown GM. *Clinical Neuroendocrinology*. Philadelphia, FA Davis Co, 1977.
14. Spitzer RL, Endicott J and Robins E: Research diagnostic criteria: Rationale and reliability. *Arch Gen Psychiatry* 35: 773-782, 1978.
15. Gold MS, Pottash ALC, and Extein I: Diagnosis of depression in the 1980's. *JAMA* 245:1562-1564, 1981.
16. Extein I, Pottash ALC, Gold MS: Relationship of thyrotropin-releasing hormone test and dexamethasone suppression test abnormalities in unipolar depression. *Psychiatry Research* 4:49-53, 1981.
17. Amsterdam JD, Winokur A, Mendels J and Synder P: Distinguishing depressive subtypes by thyrotropin response to TRH testing. *Lancet* 2: 904-905, 1979.
18. Gold MS, Pottash ALC, Extein I: Hypothyroidism and depression: Evidence from the TRH test. *JAMA* 245:1919-1922, 1981.
19. Extein I, Pottash ALC, Gold MS, Silver MJ, Mueller EW, and Sweeney DR: TRH test normalization with recovery in depression. *Scientific Proceedings, 134th annual meeting, American Psychiatric Association*, pp. 212-213, 1981.
20. Greden JF, Albala AA, Hasket RF, James NM, Goodman L, Steiner M, and Carroll BJ: Normalization of dexamethasone suppression test: A laboratory index of recovery from endogenous depression. *Biol Psychiatry* 15: 449-458, 1980.
21. Gold MS, Pottash ALC, Extein I and Sweeney DR: Dexamethasone suppression tests in depression and response to treatment. *Lancet* 1: 1190, 1980.

**“We need a system
we don’t have to
worry about”**



Dr. I. David Weisband, of the Regional Orthopedic Professional Association, is one of a growing number of physicians who've found Minicom's Medical Practice Management System meets the unique needs of a medical practice.

Automatic preparation of statements, Medicare and insurance company forms; instantaneous, up-to-the-minute accounts receivable information, plus a variety of practice analysis reports.

“We treat patients, not computers,” Dr. Weisband says, “so we need a system we don’t have to worry about.”

And our Medical Practice Management System is just that. It

features reliable Xerox Diablo equipment and is backed by our policy of Unsurpassed Service—hardware, software, training, maintenance and system back-up, all from one reliable source.

“Our office manager and accounting firm investigated alternatives,” he continues, “and recommended the Minicom system as the best solution to our needs. I agree.”

So, before you invest in a computer system for your practice, take his advice. Look into our Medical Practice Management System. Drop the coupon in the mail, or give us a call...and ask about US!

I'd like more information on Minicom's Medical Practice Management System.

Name

Address

City, State, Zip

Telephone (Area Code)

MNI



MINICOM

1415 E. Marlton Pike,
Cherry Hill, N.J. 08034
(609) 429-0600
(215) 925-6908

UNSURPASSED SERVICE

Distributors of Xerox business and professional computer systems.

**NEW YORK
FERTILITY RESEARCH
FOUNDATION, INC.**

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

Are your dental bills taking
a bite out of your savings?

ANNOUNCING:

A Medical Society of New Jersey Sponsored
GROUP DENTAL INSURANCE PLAN

FEATURING:

- "Usual, Customary and Reasonable" (UCR) benefit payments that increase with inflation
- Only a \$25 deductible
- Orthodontia benefits
- PLUS all the advantages of a group insurance program

Look for your Group Dental Insurance Plan booklet and application in the mail
Administered by

DONALD F. SMITH & ASSOCIATES

A multi-line
insurance consulting
and brokerage firm

One Airport Place, Route 206 North, P.O. Box 2197, Princeton, New Jersey 08540 (609) 924-8700 (201) 622-6046
Underwritten by New Jersey Dental Service Plan, Inc.

Infant Feeding Practices by Ethno-Cultural Grouping*

RAYMOND M. RUSSO, M.D., New Brunswick;
RAJNIKANT PATEL, M.D., TERESITA A. LAUDE, M.D.,
SOLOMON V. RAJKUMAR, M.D., Brooklyn;
VYMUUTT J. GURURAJ, M.D., Lubbock, Texas

A survey of infant feeding practices revealed that lower income families use breast-feeding and ready-prepared formulas more than before. Feeding practices do not vary markedly among five ethno-cultural groups represented.

Much of our understanding of the preference for various milk formulas and beikost^a foods offered infants in the United States is derived from the market analysis conducted by major companies producing foods for infants. Because market research is largely directed toward non-poverty groups, little is known about the feeding practices of the indigent and near indigent that comprise 11.9 percent of the United States population and 31.9 percent of the black and minority group populations.^{1,4}

The relatively few studies of lower income groups have indicated that major differences exist in the prevalence of breast-feeding and the use of evaporated milk formulas when compared with the practice of middle class and upper income populations.^{1,2,5} In 1969, Rivera gathered information on 1,414 infants, presumably of lower income families, by postcard questionnaire sent to nurses in 80 New York City well-baby clinics.² He concluded that these families relied on evaporated milk formulas more frequently than families being cared for by private pediatricians. In addition, breast-feeding was used significantly less by the mothers attending well-baby clinics.

Since this study was conducted, significant changes have been noted in the percentage of mothers using breast-feeding.⁴ The possibility was realized that similar changes may have taken place among lower socioeconomic families not only in the use of breast-feeding but in other feeding practices as well.

In addition, little is known about the different feeding norms practiced by various ethno-cultural groups in this country, particularly those that have recently immigrated.

The present study was designed with a twofold purpose in mind: (1) to assess infant feeding practices among lower socioeconomic families attending pediatric clinics in two hospitals in New York City and New Brunswick, and (2) to measure existing differences in the feeding practices of the various ethno-cultural subgroups represented in the clinic populations of both hospitals.

METHODOLOGY

Study families were selected as they registered for care in the pediatric clinics of both Kings County Hospital Medical Center and Middlesex General Hospital over a four-year period from 1976 to 1979. An effort was made to select families with children less than two years of age for interview. The following exclusions were observed:—an expressed unwillingness to participate in the study

*From the Middlesex General Hospital, New Brunswick, where Dr. Russo is Director of Ambulatory Services, and the Kings County Hospital—Downstate Medical Center, Brooklyn, NY, where Drs. Patel, Laude and Rajkumar are affiliated; Dr. Gururaj is now associated with Texas Tech University, School of Medicine, Lubbock, Texas. Correspondence may be addressed to Dr. Russo at Middlesex General Hospital, 180 Somerset Street, New Brunswick, NJ 08901.

^aInfant foods other than milk or formula.

Table 1
Study Population

	Entire Group (200)	U.S. Blacks (80)	West Indians (36)	Puerto Ricans (31)	Haitians (28)	Hispanics (21)
<u>Mother's Birth Place</u>						
U. S. Born	49%	100%	0	43%	0	5%
Non U. S. Born	51%	0	100%	57%	100%	95%

- a child too sick to be safely detained for the interview
- children with gross abnormalities of the feeding mechanism or severe mental retardation likely to interfere with feeding
- children with chronic illnesses interfering with feeding

The study population represented predominantly indigent and near indigent families of a variety of nationalities and cultures. A large percentage of non-U.S. native mothers were represented in the study sample (58.5%). The majority of these women had lived in the United States for more than five years (77.5%) and relatively few study families did not speak English regularly in the home (18.5%). Most of the parents were living together and had achieved at least some high school education. More than half of the families required some form of public assistance, e.g., Medicaid, food stamps, welfare supplementation and others, while the families not receiving some form of welfare were not much above the requisite income levels qualifying for assistance. Only six percent of the families reported an annual income above \$10,000. Forty-two percent earned between \$5,000 and \$9,999 and an additional 42 percent earned below \$5,000 a year. Ten percent did not report annual income.

The general population was divided into subgroups based on birthplace, language and/or cultural self-identification. There were five ethno-cultural groups thus defined (see Table 1). The subgroup of Caucasians (3) was too small to be considered further.

RESULTS

Two percent (4) of the mothers approached elected not to participate in the study. Two of the parents expressed a desire not to have their appointments delayed because of prior commitments elsewhere. One mother felt her infant was too sick for her to spend the additional time being interviewed. The remaining parent did not offer a reason for her refusal.

ETHNO-CULTURAL SUBGROUP DEMOGRAPHIC CHARACTERISTICS

The majority of native-born U.S. citizens were blacks and Puerto Ricans (Table 1). Almost half of the Puerto Ricans were born in the United States while virtually none of the West Indians, Haitians and non-Puerto Rican Hispanics were. On the other hand, few foreign-born mothers were recent arrivals in the United States (3.5 % <2 years). More than three-fourths had lived in the United States for more than five years. This was reflected in language use; approximately one-fifth of the families born in non-English speaking countries spoke English exclusively at home while an additional one-third spoke a mixture of English and a native tongue.

The rate of broken homes was highest among native born blacks (40%) and considerably lower in Haitian families (10%). Education levels varied considerably. West Indians and non-Puerto Rican Hispanics were more likely to have

been educated at the elementary level only, whereas few native-born blacks had not gone to high school. On the other hand, almost half the Haitians had attended at least one year of college. This appeared to have the expected economic ramifications: fewer Haitians depended on any form of public assistance than any other subgroup. At least half of all the other groups relied on public assistance.

MATERNAL ATTITUDES TOWARD BREAST-FEEDING

The majority of the 25 mothers who had attempted breast-feeding prior to the birth of the study child, i.e., their most recent offspring, found the experience satisfactory. Only a small minority of those with prior experience at breast-feeding (3) indicated the contrary to be true. There were no significant differences in this regard among the ethno-cultural subgroups except that no Haitian mothers had ever attempted breast-feeding in the past.

The rate of breast-feeding younger siblings was more than twice that for older siblings indicating an increased interest in this feeding modality among the study population. Fifty of the 59 mothers breast-feeding their most recent child had older children that they could have breast-fed if they had so desired but only 25 had done so. Besides the 59 (29.5%) mothers who attempted breast-feeding, there was an additional 14 (7%) who wished to but were precluded from trying for various reasons (Table 2). There appeared to be considerably greater interest in breast-feeding among the West Indian population than the other subgroups, a full 64 percent having actually breast-fed their infants. Native born blacks breast-fed less frequently.

The data were analyzed according to the families' economic level. Of the 117 families dependent in part or wholly on public assistance, 32 (27%) breast-fed their infants, compared to 26 (33%) of the families not depending on public assistance.

Of the 59 mothers who attempted breast-feeding, it was possible to document the length of time it was continued in 53 (Table 2). The average length of time for the entire study group was 6.8 weeks. Non-Puerto Rican Hispanics (10.2 weeks) and West Indians (8.7 weeks) exceeded the group average while Haitians (2.3 weeks) ranked far below.

The majority of breast-feeding mothers (57%) recalled terminating breast-feeding abruptly rather than gradually.

MATERNAL ATTITUDES TOWARD FORMULA FEEDING

The group's preference in using the various milk formulas and substitutes also was assessed.

Of the 200 study mothers, 189 (94.5%) had used an artificial formula feeding or whole cow's milk either in conjunction with or as a substitute for breast-feeding during the first four months of infancy. The most widely used milk feeding was Similac (41.5%) followed by ordinary cow's milk (31%), an evaporated milk formula (14%), Enfamil (4%), SMA and other canned milk formulas (2.5%). The remaining

Table 2
Number of Breast-Feeding Mothers and
the Duration of Breast-Feeding by Ethno-Cultural Subgroups

	Number and Percent Breast-feeding	Average Duration (in weeks)
U. S. Blacks	12 (15%)	6.3
West Indians	23 (64%)	8.7
Puerto Ricans	11 (34%)	6.4
Haitians	6 (21%)	2.3
Hispanics	7 (33%)	10.2
Entire Study Group	59 (29.5%)	6.8

Table 3
Formula Feeding Preference by Ethno-Cultural Subgroups

	Evaporated Milk	Canned Milk Formulas			Milk Substitute
		Similac	Enfamil	Other	
Entire Study Group	14%	41.5%	4%	2.5%	7%
U.S. Blacks	19%	35%	2%	0	10%
West Indians	6%	31%	5%	3%	9%
Puerto Ricans	6%	34%	6%	0	3%
Haitians	21%	46%	22%	0	0
Hispanics	14%	48%	14%	0	5%

(7%) used a variety of hypoallergenic milk substitutes (Table 3). There were no significant subgroup trends noted except that Puerto Rican mothers favored the use of whole cow's milk more than other mothers.

Families on welfare tended to use evaporated milk formulas somewhat more (11%) than those who were not receiving assistance (6%).

The switch from formulas or breast milk to fresh whole cow's milk was documented in 89 of the 200 study families. In 34 (38%) this was accomplished by four months of age while 55 (62%) children were continued into the fifth month. Thereafter, there was a rapid changeover so that less than ten percent of families were using formula feedings beyond six months of age. Puerto Ricans tended to use fresh whole cow's milk earlier than other mothers.

VITAMIN AND IRON USAGE

Each subgroup closely paralleled the entire population's use of vitamins (Table 4). Almost three-quarters of the mothers claimed to have used vitamins regularly during their infants' first few months of life. It is interesting to note that nearly half the mothers could not recall having consulted a physician prior to administering vitamins to their babies, yet very few claimed to have used them on their own initiative or with the help of other possible advisors.

Exactly one-third of the mothers reported using iron supplements in addition to the iron already contained in some formulas. Seventeen study infants were identified who had diets deficient in iron intake. These were infants fed an iron-poor formula, e.g., Enfamil or Similac without iron. Thus, 8.5 percent of the study population was considered to be at risk for developing iron deficiency anemia; and, in fact, 43 percent of these had mean corpuscular hemoglobin concentration below 33 percent.

INTRODUCTION TO BEIKOST

Almost half the study mothers indicated that they relied on themselves or the advice of non-physicians in initiating beikost feedings. This was especially true of native born blacks and Hispanics but common to the other subgroups as well.

Cereal was the solid food most often introduced first.

Fruits and vegetables were started between two and three months of age, desserts between three and four months, and eggs between the fourth and fifth month. The subgroups differed little in these practices, West Indians tending to introduce beikost feeding a little later than the other groups.

COMMENTS

The study population is clearly a mixed ethnic group of native United States-born blacks and immigrants from the Caribbean area. They appear to be representative of the lower socioeconomic population currently living in urban centers of the U.S. Northeast.

The study indicates that there is a growing interest in breast-feeding among the lower socioeconomic population comparable to other income groups.

Twenty-nine percent of the mothers relied on breast-feeding. This is in close agreement with Filer's recent report indicating that 38 percent of U.S. women in general and 25 percent on the East coast currently practice breast-feeding.⁴ It is also in general agreement with Martinez and Nalezienski's recent report showing a substantial increase in the percentage of breast-feeding mothers in all demographic groups surveyed by mailed questionnaires from 1975 to 1979.¹² In the latter study, 37 percent of families with less than \$7,000 annual income, breast-fed their infants. This result compares with our finding that 27 percent of mothers on public assistance were breast-feeding. However, it is in marked contrast to older surveys^{2,4,7-10} which clearly documented an infrequent use of breast milk.

An increasing reliance on breast-feeding was observed

"Families on welfare tended to use evaporated milk formulas somewhat more (11%) than those who were not receiving assistance (6%)."

Table 4
Use of Vitamins

	Vitamin Supplementation	
	Yes	No
Entire Study Group	71%	21.5%
U. S. Blacks	70%	23%
West Indian	69%	25%
Puerto Rican	69%	13%
Haitians	82%	18%
Hispanics	62%	33%

within the study population. Older siblings of the study families were breast-fed only half as often as the most recently born siblings. The recent advent in the New York area of greater numbers of West Indians who appear to practice this mode of infant feeding far more than other groups (64%) has contributed to this trend. Forty-four percent of the West Indians in the study population had arrived in the U.S. within the last five years. However, this reason alone is insufficient to explain the general increase in interest in breast-feeding.

The duration of breast-feeding observed parallels Filer's report that at age two months, two-thirds of the nation's breast-fed infants are switched to other nutritional sources.⁴ Only Haitians appear to vary markedly in this respect terminating feedings after little more than two weeks. The switch from formula or breast to fresh milk occurred between four and six months of age.

Relatively few mothers were currently relying on evaporated milk formulas (14%) in marked contrast to the older studies when they were used by 30 to 40 percent.^{2,6,7,9} This would indicate a decided trend away from evaporated milk formulas in lower socioeconomic families. Welfare families used evaporated milk almost two times as much as non-welfare families but among either group the percentage is small. This finding corroborates a recent survey of national trends.¹²

The inadequacy of professional guidance to low income population in this area of infant nutrition was apparent from our study data. A high percentage of infants in all subgroups was given vitamins regularly in the first months of life. In half of these instances, mothers could not recall having consulted a health professional about vitamin usage indicating deficiencies in the process of educating parents about infant feeding.

The corollary to this was the identification of seventeen infants being fed breast milk or formulas deficient in iron who were not using iron supplementation. Almost half of these had developed evidence of iron deficiency anemia. In a population now relying frequently on canned milk formulas, particularly Similac without iron, and often not receiving professional advice on infant feeding, the potential for developing iron deficiency is great.

"In a population now relying frequently on canned milk formulas, particularly Similac without iron, and often not receiving professional advice on infant feeding, the potential for developing iron deficiency is great."

The same lack of professional guidance was apparent when beikost feedings were introduced. Almost half of the mothers relied on their own judgment or advice from friends in making these decisions. However, there did not appear to be much variation from national norms with regard to beikost feedings. Welfare mothers started baby foods earlier than non-welfare mothers. There were also subgroup differences; West Indians delay beikost feedings more than other subgroups. It is worth noting that a significantly large percentage of infants (31.5%) were not fed by their mothers exclusively. In planning education programs on infant feeding and while giving nutritional advice to clinic families, this should be taken into account. It may very well be that we are not always educating the individuals who need it most.

SUMMARY

The infant feeding practices of lower income families were assessed at two hospitals in the New York-New Jersey area. Five major ethno-cultural subgroups were identified among the 200 families interviewed.

Comparison with older surveys revealed changing feeding practices: low income mothers in the area studied are utilizing breast-feeding and ready-prepared infant formulas to a greater extent than before. Feeding practices do not appear to vary markedly among the five major ethno-cultural subgroups identified. However, West Indians breast-feed far more frequently than the norm for the study population or the nation. Puerto Ricans use fresh cow's milk earlier in infancy and more frequently in preference to other types of milk.

The use of vitamin and iron supplements appeared to reflect the inadequacies of the area's health care delivery system in that almost half the mothers using them regularly had received no feeding counseling. Of the 17 infants being fed iron-poor formulas, almost half had evidence of iron deficiency anemia.

The large percentage of infants (31.5%) being fed regularly by a second party feeder would suggest that counseling programs need to address this possibility.

REFERENCES

1. Fomon SJ: What are infants fed in the United States? *Pediatr* 56:350-354, 1975.
2. Rivera J: The frequency of use of various kinds of milk during infancy in middle and lower income families. *Am J Pub Health* 61:277-280, 1971.
3. Manpower report of the President. U.S. Government Printing Office. Washington, D.C. April, 1974.
4. Filer LJ Jr: Reported at Harold C. Mack Symposium, 1976.
5. 1970 United States Census of Population and Housing. U.S. Bureau of the Census, Washington, D.C.
6. Harris LE, Chan JCM: Infant feeding practices. *Am J Dis Child* 117:483-491, 1969.
7. Meyer HF: Breast-feeding in the United States. *Clin Pediatr* 7:708-715, 1968.
8. Ho CH, Brown ML: Food intake of infants attending well-baby clinics in Honolulu. *J Am Diet Assoc* 57:17-21, 1970.
9. Maslansky E, Cowell C, Carol R, Berman SN, Grossi M: Survey of infant feeding practices. *Am J Pub Health* 64:780-785, 1974.
10. Fomon SJ: *Infant Nutrition*, ed 2. Philadelphia, Saunders, 1974.
11. Filer LJ Jr, Martinez GA: Caloric and iron intake by infants in the United States: An evaluation of 4,000 representative six-month olds. *Clin Pediatr* 2:470-476, 1963.
12. Martinez GA, Nalezienski JP: 1980 Update: The recent trend in breast-feeding. *Pediatr* 67:260-263, 1981.

Part I: Prolactin and Its Physiology *

E. KEMMANN, M.D. and J. R. JONES, M.D., Piscataway

In human serum prolactin (PRL) can be detected usually at levels of less than 20 ng/ml. PRL is released from the pituitary gland and under constant inhibitory control by the hypothalamus, apparently via a dopaminergic mechanism. Of the many potential physiologic effects of PRL, only initiation and early maintenance of lactation are clearly recognized in humans. Physiologic events which may increase PRL release are discussed.

The significance of a determination of a plasma prolactin (PRL) level in clinical medicine only recently has been appreciated. A prerequisite was the development of a sensitive radioimmunoassay to enable us to understand the physiology and pathophysiology of PRL secretion.¹

STRUCTURE AND REGULATION

Human pituitary PRL is structurally similar to, but biologically distinct from both human growth hormone and placental lactogen. PRL contains about 198 amino acids and has a molecular weight of approximately 200,000.² It is secreted episodically by specific anterior pituitary cells, the lactotropes, which appear to be in close approximation to the gonadotropin-producing cells. The lactotropic cells appear (with light microscopy) as chromophobe cells.³

Serum levels of PRL are detectable in both males and females. The normal serum concentration of PRL in men and non-pregnant women is less than 20 ng/ml. The half life of PRL in blood is about 15 to 20 minutes. Both men and women display a circadian rhythm in the secretion of PRL with the highest levels achieved during non-REM sleep.⁴

Prolactin, unlike most other hormones of the anterior pituitary, is not under the regulation of a peripheral feedback system. The major control of pituitary PRL secretion is via an inhibitory hypothalamic hormone, prolactin inhibitory factor (PIF).⁵ The primacy of a hypothalamic inhibitory control of an anterior pituitary hormone is characteristic of

hormone systems in which there is no peripheral feedback hormone. Numerous data strongly suggest that PIF, which is a dopaminergic factor, is dopamine.^{6,7} PIF enters the anterior pituitary from the hypothalamus via the portal vessels and suppresses the lactotropic cell production and release of PRL (Figure 1). It has been postulated that there is also a prolactin-releasing factor (PRF), but this never has been clearly described.⁸ Thyrotropin-releasing hormone (TRH) stimulates the anterior pituitary gland to secrete thyrotropin as well as PRL, but the physiologic relevance of this mechanism remains in question.⁵

Factors which tend to inhibit PIF release (and thereby increase PRL secretion) also seem capable of suppressing hypothalamic-pituitary gonadotropic function; however, the precise mechanism by which a decrease in PRL control is related to a decrease in luteinizing-hormone releasing hormone (LRH) and gonadotropins is unknown. One possibility is based on the fact that PIF and LRH are linked by common neurotransmitters. Thus a disruption in the hypothalamic dopamine regulation could also interfere with the release of norepinephrine and thus LRH.

A variety of *in vitro* observations have noted that PRL is necessary in the maintenance of adequate testicular pools of

*From the Department of Obstetrics and Gynecology, CMDNJ-Rutgers Medical School, where Dr. Kemmann is Associate Professor and Dr. Jones is Professor and Chairman of the Department. Correspondence may be addressed to Dr. Kemmann at the school, P.O. Box 101, Piscataway, NJ 08854.

Hypothalamus

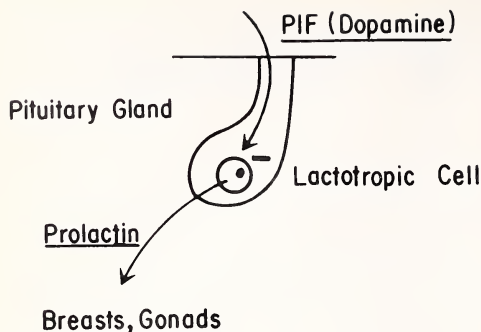


Figure 1: Hypothalamic control of pituitary prolactin secretion.

precursors for testosterone formation. Prolactin appears to diminish the enzymatic activity of 5α -reductase, an important step in testosterone metabolism.⁹ Together with testosterone PRL helps to maintain seminal vesicle and prostate functions in rodents. There is some suggestion that impotence may be associated with hyperprolactinemia.¹⁰ Occasional observations in some oligospermic men have shown elevated levels of PRL but it is not known whether the hyperprolactinemia is etiologic or rather a secondary phenomenon.

In regard to the ovary it has been shown in many species that PRL stabilizes the LH receptor and thus is luteotrophic (maintaining corpus luteal function), yet its luteal effects in women are unknown.¹¹ There is some evidence that elevated levels of PRL affect ovarian function directly.¹²

NONGONADAL EFFECTS

In the human the only clearly defined function of pituitary PRL is the initiation and early maintenance of lactation in women. The role of prolactin in males is unknown. Although other hormones (thyroxine, cortisol, insulin, progesterone, estrogens, and so on) are certainly of importance in lactation, PRL appears to be the single, most decisive factors in the entire lactation process.^{13,14} Prolactin directly stimulates lactopoesis in the alveolar cells of the breast.

A great deal of literature has appeared concerning possible nonlactogenic effects of PRL and although much of the data are tentative, the wide variety of possible PRL effects are worth noting.

Prolactin receptors have been found in the kidney. A number of animal studies have shown that PRL can cause sodium, potassium and water retention and potentiate the renal effects of aldosterone and anti-diuretic hormone, but data supporting the role of PRL in water metabolism in man are lacking.¹⁵

Recently a substance similar in structure to pituitary PRL has been found to be produced by the premenstrual endometrium and by uterine decidual tissue.¹⁶ Studies of amniotic fluid have revealed high levels of PRL the significance of which is uncertain.¹⁷ It seems possible that this hyperprolactinemic milieu may play a role in water metabolism in the fetus.

Effects of PRL on calcium metabolism, the cardiovascular system, thyroid function and adrenal cortex secretion all

have been described but work in these areas is still in early stages.¹⁵

To date there has been no evidence that hyperprolactinemia in the human is associated with a higher risk for the development of breast cancer. Most studies of women with breast cancer have not indicated abnormalities of serum PRL levels.⁸ Nevertheless, concern will continue to exist since it is well established that in certain rodents the development of breast tumors is prolactin dependent.¹⁸

PHYSIOLOGIC HYPERPROLACTINEMIA

In a number of physiologic situations PRL level can be found to be elevated. PRL responds as a stress hormone and is released in increased amount after surgery, hypoglycemia or vigorous exercise as is growth hormone and ACTH.^{19,20} Also PRL levels undergo a circadian rhythm with a nadir at night; conventionally blood for the determination of PRL level is taken in the morning.

Prolactin is elevated normally in the fetus and in the neonate. In women the increases in PRL level during pregnancy and early lactation may reach levels of 200 ng/ml or more. Of particular interest in this physiologic hyperprolactinemia of pregnancy is the seemingly paradoxical role of estrogens.¹⁴ During pregnancy estrogens stimulate the secretion of pituitary PRL but inhibit the actual process of lactation in the breast. At the time of delivery, the placenta—the source of estrogens—is removed and within 24 to 36 hours the patient experiences a rather profound hypostrogenism. The breasts, whose acinar and ductal development were further enhanced during pregnancy, are no longer under the secretory inhibition of estrogens and start to secrete milk. Oxytocin facilitates lactation via the milk-ejection reflex. With suckling, a second neurogenic reflex is triggered leading to spikes of PRL release superimposed on already elevated PRL baseline levels.²¹ Despite continued lactation, in subsequent weeks elevated levels of PRL will decline. Ultimately lactation may be maintained with normal PRL levels.¹⁴ Thus elevated PRL levels are not necessary for the maintenance of lactation.

SUPPRESSION OF PROLACTIN LEVELS FOR PREVENTION OF POSTPARTUM LACTATION

If a patient does not breast-feed, lactation will be suppressed by the avoidance of nipple stimulation. Conventionally, to reduce accompanying breast swelling and tenderness mechanical means (breast binding), along with analgesics and sex hormones (specifically estrogens and androgens) have been used. With the elucidation of the critical role of PRL in the initiation of the lactation process, successful attempts have been made to prevent lactation by reducing PRL levels after delivery. As a result of such studies, bromocryptine mesylate (Parlodol®) recently became available; it offers the possibility to suppress lactation effectively without using estrogens or androgens. Clinical data show that PRL levels are reduced to "normal" levels within a day, in a majority of patients, and clinical symptoms of breast tenderness or pain are virtually absent.²² Currently the recommended dosage is of 2.5 mg of bromocryptine twice a day (with meals) for 14 days; it should be started after the patient's vital signs have been stabilized, but no sooner than four hours after delivery. Bromocryptine does have side effects (i.e., nausea, hypotension, dizziness) which are further discussed in Part II.

Part II: Hyperprolactinemia— Diagnosis and Management*

E. KEMMANN, M.D. and J.R. JONES, M.D., Piscataway

Abnormal elevation of serum prolactin (PRL) levels occurs in a number of clinical situations. The indications for the measurement of PRL levels are discussed, and a differential diagnosis of hyperprolactinemia is present. Most important is the detection or exclusion of a pituitary adenoma. Controversies around the specific management of "microadenoma" are presented. The use of bromocryptine mesylate in the treatment of hyperprolactinemia is reviewed.

Radioimmunoassay measurement allows a precise and accurate determination of plasma PRL levels; generally levels of 20 ng/ml or above are abnormal and indicate hyperprolactinemia. Prolactin measurements are indicated in a number of clinical situations based on the differential diagnosis of pathologic hyperprolactinemia (see Table).

A close functional relationship between the hypothalamus and the pituitary gland usually controls PRL secretion and is potentially susceptible to derangement by organic lesions involving this anatomic area. Therefore any male or female patient who is suspected of having an organic pituitary or parapituitary lesion deserves an investigation of PRL secretion.²³ In addition to baseline levels of PRL, dynamic tests of PRL release can be used. In a stimulation test, PRL reserve may be assessed after the administration of chlorpromazine or TRH.^{14,23} In suppression testing the dopamine agonists L-dopa may be used to decrease elevated PRL levels.²³ These dynamic tests are primarily advocated to distinguish between hyperprolactinemia due to a pituitary adenoma *versus* non-organic, "dysfunctional" causes. Preliminary data suggest that the TRH test has some diagnostic value in this regard.

As increased PRL secretion may lead to either galactorrhea or amenorrhea or both, women in the reproductive years have clear clinical markers suggestive of hyperprolactinemia.^{5,24}

Infertility due to nonovulation is frequently the presenting symptom. Hyperprolactinemia appears to be uncommon in

Table

Differential Diagnosis of Hyperprolactinemia

- A. Physiologic Causes
 - Stress; Pregnancy and Lactation
 - Nycturnal Rhythm
 - Fetal and Neonatal Development
- B. Pituitary/Parapituitary Lesions
 - Prolactinoma; Other Pituitary Tumors
 - Stalk Section; Post Pituitary Surgery
 - "Empty Sella" syndrome; Pituitary Cysts
 - Granulomatosis; Hypothalamic Lesions
- C. Drugs
 - Estrogens; TRH; β -Endorphin
 - Heroin
 - Reserpin; Aldomet
 - Phenothiazides; Imipramines; Haloperidol
- D. Idiopathic Causes
 - Chiari-Frommel Syndrome
 - Argonz-Del Castillo Syndrome
 - Postpill Galactorrhea-Amenorrhea
- E. Other
 - Metabolic Causes: Uremia; Hypothyroidism
 - Ectopic Production: Bronchogenic Ca; Hypernephroma
 - Chest Wall Injury

*From the Department of Obstetrics and Gynecology, CMDNJ-Rutgers Medical School where Dr. Kemmann is Associate Professor and Dr. Jones is Professor and Chairman of the Department. Correspondence may be addressed to Dr. Kemmann at the school, P.O. Box 101, Piscataway, NJ 08854.

children or postmenopausal women, but clinical stigmata such as galactorrhea or amenorrhea are not available. Recently, we reported on the association of hyperprolactinemia in patients with primary amenorrhea.²⁵ In males, decreases in libido, impotence¹⁰ and abnormalities in breast development (galactorrhea or gynecomastia)¹⁴ are symptoms and signs which should initiate an investigation for hyperprolactinemia.

Galactorrhea is defined as the inappropriate secretion of milk (Figure 2). Patients may not be aware of its presence, thus it is up to the physician to examine the areolar area and nipple of the breasts specifically for the presence of "milk." Usually at the end of a breast examination for cancer, the breast and the nipple are centripetally massaged to look for a discharge.²⁶ There are other breast secretions than galactorrhea; occasionally non-lactational nipple discharge may indicate the presence of occult cancer.²⁷ In multiparous women a drop of serous fluid commonly is present and apparently of no consequence. Galactorrhea may not necessarily be associated with hyperprolactinemia; indeed when galactorrhea is found in a woman having normal, regular cycles, the prolactin levels are often normal. Galactorrhea, on the other hand, is not present in all patients with hyperprolactinemia.



Figure 2: Galactorrhea.

CAUSES

Pituitary/Parapituitary Lesions—Any patient with hyperprolactinemia should be evaluated for the presence of a pituitary tumor.^{5,14,23,28} Tomogram studies of the sella turcica are the diagnostic method of choice.^{29,30} If there is no radiographic evidence of a tumor on the initial examination, a hyperprolactinemic patient should be followed carefully over a period of years to exclude the possibility that an undetectable tumor is developing.

The prolactin-secreting pituitary adenoma or "prolactinoma" appears to be the most common pituitary tumor in women. Typically serum follicle stimulating hormone (FSH) and luteinizing hormone (LH) levels are suppressed (usually less than 12 mIU/ml) and the prolactin levels are quite high (often more than 100 ng/ml). In the majority of adenomas the remainder of the anterior pituitary function, namely growth hormone secretion, control of thyroid function and of adrenal function, appears not to be impeded. The distinction between a micro- and macroadenoma is clinically useful.^{29,30} In a patient with a microadenoma the sella volume is still within normal limits and radiographic changes may be minimal (Figure 3). Radiographic changes may consist of thinning of the floor with erosion and "blistering," a "double floor," or asymmetry of the fossa.³¹ Early changes are subtle and easily overlooked, and often can be delineated only by polytomography of the sella. Computerized-axial-tomography (CAT scan) so far has not been found to be of help in the diagnosis of microadenomas.³² Patients with microadenomas do not have visual field changes as the lesion is confined within the sella. In the macroadenoma the volume of the sella is increased due to a lesion exceeding one cm in diameter, and the growth may extend into the area of the third ventricle or compromise the optic chiasm and other adjacent structures. With large lesions the endocrine function of the anterior pituitary gland may become significantly compromised.

Whereas large or enlarging prolactinomas pose an obvious threat to the health of the patient, the implications of the presence of a prolactin-secreting microadenoma are less

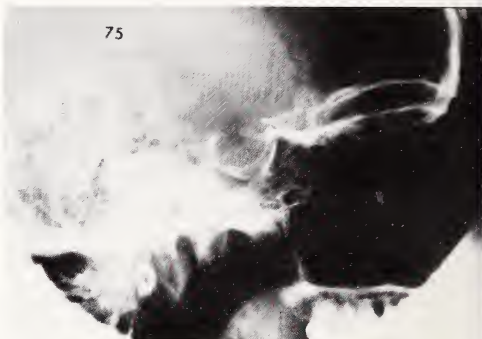


Figure 3: Radiograph of a prolactin-secreting pituitary adenoma (surgically confirmed).

clear. The natural course in the development of these lesions is not known. Rarely do such lesions enlarge rapidly. They may grow slowly or not at all while some lesions may regress spontaneously.³³ It should not be left unmentioned that small, subclinical pituitary adenomas have been reported as incidental findings in several autopsy studies in a significant number of cases (about five percent).^{32,34}

Hyperprolactinemia may be caused by pituitary tumors other than a prolactinoma. A tumor may concomitantly secrete prolactin or a prolactin-like substance or interfere with the hypothalamic inhibitory control. Pituitary and hypothalamic lesions caused by sarcoidosis, granulomatous diseases, craniopharyngeoma, or metastatic carcinoma could lead to hyperprolactinemia. Hyperprolactinemia may result from the disruption brought about by pituitary surgery.

Of particular interest in the differential diagnosis of pituitary lesions is the "empty sella" syndrome; it represents a congenital or acquired herniation of the subarachnoid space into the pituitary fossa with compression of the pituitary gland. In some patients it may represent the end stage of a necrotic, "burned-out" pituitary tumor. Endocrine manifestations vary and are not consistent but hyperprolactinemia may be present.³⁵ Pneumoencephalography, with the demonstration of air in the sella turcica, is an essential part of the preoperative evaluation of patients with suspected pituitary tumors.³²

Drug Induced Hyperprolactinemia—A number of en-

ogenous substances, specifically estrogens, TRH and endorphins, are potent releasing agents for PRL.⁵ It appears that estrogens are responsible for the slightly elevated baseline levels of PRL in women as compared to men and are of importance in the marked increase of PRL in pregnancy. The physiologic relevance of PRL secretion secondary to TRH or endorphin stimulation remains unclear. The exogenous administration of these agents also increases PRL secretion.

A growing list of pharmacologic agents, which will stimulate PRL release includes drugs of major clinical importance such as phenothiazide derivatives (Stelazine®, Mellaril®, Thorazine®).⁸⁻¹⁹ Chlorpromazine (Thorazine®) is used as a test of pituitary prolactin reserve.¹⁴ These drugs seem to act as dopamine receptor antagonists thereby producing a mild to moderate increase in PRL levels.³⁶ Other pharmacologic mechanisms of action are exemplified by α -methyl-dopa and reserpine causing dopamine competition or depletion, respectively. If hyperprolactinemia appears drug-induced and the medical condition of the patient requires further use of the specific drug, hyperprolactinemia may have to be accepted as a side effect. Nevertheless a radiographic study of the sella should be done to rule out a pituitary lesion. Amenorrhea in heroin users may, in part, be explained as a result of drug-induced hyperprolactinemia.

Idiopathic—Idiopathic or “dysfunctional” hyperprolactinemia includes syndromes which have been described by past clinical experience prior to the availability of PRL determinations. The Chiari-Frommel, the Argonz-Del Castillo and the “postpill galactorrhea-amenorrhea” syndromes can be named here. Although these entities were originally described as not being caused by pituitary tumors, patients diagnosed with these problems on occasion do have a subclinical prolactinoma which becomes evident with long followup. On occasion a patient with a dysfunctional galactorrhea-amenorrhea syndrome may be found to have a normal serum PRL level. It is postulated that the patient's PRL level had been elevated in the past and the galactorrhea-amenorrhea syndrome persists despite the normalization of PRL levels.

The Chiari-Frommel syndrome, which is seen in both nursing and non-nursing women, is defined as amenorrhea-galactorrhea persisting in a patient for an excessive period of time after a pregnancy.³⁷ In many patients milk discharge may be copious but in some patients it is demonstrable only by manual expression. Usually there is hypoplasia of the uterus, atrophic endometrium and small ovaries. Endocrinologically these patients are hypogonadotropic with decreased levels of FSH and LH and low estrogens. The PRL levels usually are elevated but rarely exceed 100 ng/ml. The sella turcica is normal.

The Argonz-Del Castillo syndrome (also Ahumada-Del Castillo syndrome) is characterized by “idiopathic” amenorrhea and galactorrhea.³⁸ Clinically similar to the Chiari-Frommel syndrome, patients with the Argonz-Del Castillo syndrome mainly differ in that they had no preceding pregnancy.

A syndrome of hyperprolactinemia-amenorrhea occasionally is seen after exposure to oral contraceptives and referred to as the “postpill galactorrhea-amenorrhea” syndrome.³⁹ Whether its development is related to or masked by oral contraceptives is an ongoing controversy. Clinically it differs little from either the Del Castillo or Chiari-Frommel syndrome. It is important to rule out the presence of a prolactinoma, which is seen in a high percentage of women

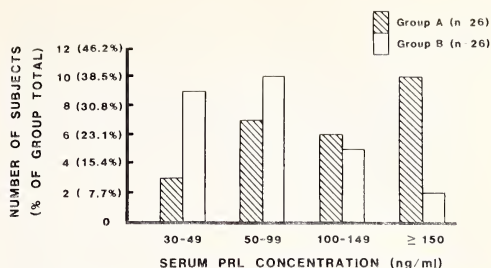


Figure 4: Distribution of serum prolactin levels in women with pituitary lesions (prolactinomas), Group A, versus women with idiopathic hyperprolactinemia, Group B.

with postpill galactorrhea-amenorrhea.⁴⁰ Generally patients with idiopathic hyperprolactinemia tend to have PRL elevations to a lesser degree than hyperprolactinemic patients with a radiographically abnormal sella; PRL levels in excess of 100 ng or more frequently are seen in women with prolactinomas (Figure 4).

Other Disorders—Primary hypothyroidism results in an increased secretion of TRH and thyrotropin (TSH). Since TRH is also a potent stimulant of prolactin release, hyperprolactinemia and its clinical consequences may result.⁴¹ Therefore, patients with hyperprolactinemia should have an assessment of their thyroid status.

Chronic renal failure is associated with hyperprolactinemia, the etiology of which is unclear.⁴²

Abnormal PRL secretion has on occasion been caused by ectopic production of PRL by a bronchogenic carcinoma, or a hypernephroma.⁸

In some patients a mild elevation of PRL levels has been noted after a chest wall trauma.⁴³ Such trauma may include herpes zoster or surgical procedures such as thoracotomy or thoracocentesis. It appears that the mechanism of prolactin release is neurogenic, which is similar to that seen physiologically in suckling during postpartum lactation.

MANAGEMENT OF HYPERPROLACTINEMIA

Treatment of hyperprolactinemia depends on an accurate diagnosis of the cause of the deregulation of PRL secretion. If metabolic problems (hypothyroidism, renal failure, and so on) are recognized, their correction usually will also lead to normoprolactinemia. In cases of drug-induced hyperprolactinemia it may be necessary to accept hyperprolactinemia as a side effect. Most patients, however, have hyperprolactinemia either due to a prolactinoma or idiopathic cause and in these patients sometimes difficult therapeutic choices have to be made.

A distinction has been made between “macro” and “micro” forms of the prolactinoma. Probably no controversy exists concerning an enlarging lesion or a macroadenoma which requires active intervention. Prior to any therapy an evaluation of the pituitary lesion should include radiographic and neurologic studies to delineate the size of the tumor, and to exclude the possibility of the “empty sella,” pituitary cysts or a vascular abnormality. Endocrine studies should evaluate the functional competence of the pituitary gland. Surgically, transphenoidal partial hypophysectomy has become a major treatment modality specifically for lesions which do not extend into the brain; this approach appears relatively safe and effective and usually does not lead to permanent hypopituitarism.^{39,44} For larger lesions extending into the

"Women with microadenomas who want to get pregnant present a rather specific problem."

brain, a transfrontal approach generally is advocated. Radiation therapy is an alternative approach and specific centers advocate the use of proton beam radiotherapy.^{28,45} A major drawback of radiation therapy is that ultimately it leads to hypopituitarism in a high percentage of patients. The place of medical therapy with bromocryptine in the treatment of large pituitary prolactinoma lesions is under active investigation with rather promising leads.

Major controversies exist in the management of microprolactinomas. Microadenomas can be removed (via the transsphenoidal approach) with good clinical success. But it is apparent that in a considerable number of patients such lesions seem not to progress or to interfere with the welfare of the patient. Thus the apparent benignity and nonaggressiveness of these lesions may allow a more conservative approach.⁴⁵ We, therefore, generally prefer to follow these patients with serum PRL levels every six months and lateral sella turcica films (initially every six months, then every year). If patients present evidence of progression of the lesion, surgical therapy may be recommended. However, most patients seem not to show significant progression and, on occasion, even spontaneous regression of pituitary adenomas can be observed. Again, the use of medical suppression treatment with bromocryptine appears promising and is under investigation at several universities.

Women with microadenomas who want to get pregnant present a rather specific problem.⁴⁶ Although ovulation can be induced in such patients rather easily by the use of appropriate medication (bromocryptine or exogenous gonadotropins) they have a space-occupying pituitary lesion which may interfere with the physiologic enlargement of the pituitary in pregnancy. Headaches, excessive nausea and vomiting and disturbance of vision are signs that may indicate that rapid pituitary enlargement and compression is taking place in such patients. They may have to undergo emergency hypophysectomy during pregnancy or be treated with specific medication to reduce the pituitary enlargement. In order to avoid this possible complication, consideration should be given to transsphenoidal surgery in those patients prior to conception. Recent data, however, seem to indicate that this pituitary compression in pregnancy is a rather unusual event in patients with microadenomas. It is our policy to stimulate ovulation in the patient with pituitary microadenoma and watch her carefully through pregnancy.

Patients with idiopathic hyperprolactinemia present a continuous diagnostic challenge as it is possible that a subclinical prolactinoma ultimately may become evident. Thus a regimen of periodic surveillance must be instituted. In order to reduce radiation exposure of the pituitary, we use only one yearly lateral x-ray of the sella turcica; plasma PRL is measured biannually. Medical treatment to reduce PRL levels is available and will lead to temporary drug-induced

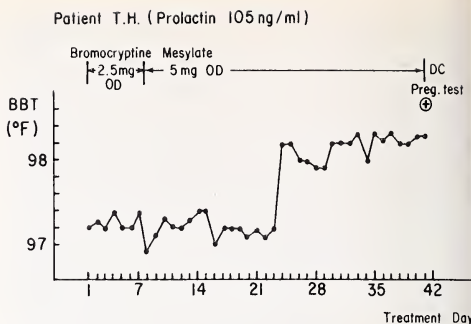


Figure 5: Basal body temperature chart of a woman with hyperprolactinemia under bromocryptine therapy; patient conceived three weeks after initiation of therapy and medication was stopped once a positive pregnancy test was obtained.

normoprolactinemia but not to "cure"; PRL levels will usually rise again once the medication is discontinued.⁴ Treatment is usually associated with a return of cyclic ovarian function with ovulation; thus the need for contraception may arise. For this reason the rationale for medical therapy is debatable in women with idiopathic hyperprolactinemia unless ovulation is to be induced for pregnancy, or galactorrhea is excessive and causes embarrassment. The only drug currently used for treatment of hyperprolactinemia is bromocryptine mesylate (Parlodel®). Other drugs that effectively lower elevated serum prolactin levels are L-dopa and apomorphine.

USE OF BROMOCRYPTINE MESYLATE

Bromocryptine mesylate is a dopamine agonist and inhibits PRL secretion primarily at the pituitary level. It also allows, directly or indirectly, the return of cyclic hypothalamic-pituitary gonadotropin release. With the reduction of PRL levels galactorrhea will cease quickly and ovulation usually will resume within several weeks.⁴⁷ Clinical treatment consisting of a daily oral administration of 2.5 to 7.5 mg bromocryptine, frequently is associated with side effects such as nausea, vomiting and dizziness. It is advisable to start at a lower dosage and increase the dosage gradually. If pregnancy occurs, the medication should be withheld (Figure 5).

Bromocryptine has been used to induce ovulation and has resulted in pregnancy in infertile women with hyperprolactinemia.⁴⁸ FDA regulations, however, currently do not sanction the use of this medication for this specific purpose and state that although the drug can be used to treat galactorrhea-amenorrhea secondary to hyperprolactinemia, it is not "indicated" for the induction of ovulation. The experience with the drug thus far is too limited in terms of numbers of pregnancies achieved; years of followup of the offspring will be necessary to unequivocally demonstrate that there are neither any teratogenic potential or other long-term problems. However it is somewhat reassuring to note that until today rates of malformations, abortions and multiple gestation are similar to those seen in a normal population. The availability of the drug opens the possibility to use it in infertility patients who want to conceive. If it is done, patients should be made aware of the current controversy so that they participate intelligently in such a difficult decision. Alternate methods to induce ovulation in women with idiopathic hyperprolactinemia are limited. The use of

clomiphene citrate is usually not effective in this patient group; menopausal gonadotropins (Pergonal®) are quite effective but their use should be limited to centers with adequate biochemical monitoring methods.

The use of bromocryptine in the suppression of lactation has been discussed in Part I.

SUMMARY

In the last decade the ability to measure serum PRL levels has led to the characterization of hyperprolactinemia as a clinical entity. In women, galactorrhea and/or amenorrhea are symptoms of elevated PRL levels; in males impotence seems to be a clinical correlate. In the differential diagnosis of hyperprolactinemia, concern about the presence of a pituitary adenoma, specifically the prolactinoma, is preeminent. Management of small lesions (microadenomas) is controversial, as both active therapy or conservative follow-up are advocated. For larger lesions, neurosurgery or radiation becomes necessary. The differential diagnosis of hyperprolactinemia is discussed. Recently medical treatment to reduce elevated PRL levels has become available.

REFERENCES

1. Hwang P, Guyda H, Fiensen H: A radioimmunoassay for human prolactin. *Proc Nat Acad Sci USA* 68:1902-1906, 1971.

2. Showe B, Parlow AF: Human pituitary prolactin (hPRL): The entire linear amino acid sequence. *J Clin Endocrinol Metab* 45:1112-1115, 1977.

3. Zimmerman EA, Defendini R, Frantz AG: Prolactin and growth hormone in patients with pituitary adenomas: A correlative study of hormone in tumor and plasma by immunoperoxidase technique and radioimmunoassay. *J Clin Endocrinol Metab* 38:577-585, 1974.

4. Parker DC, Rossman LG, Vanderlaan EF: Relation of sleep-entrained human prolactin release to REM-non REM cycles. *J Clin Endocrinol Metab* 38:646-651, 1974.

5. Frantz AG: Prolactin. *N Engl J Med* 298:201-207, 1978.

6. MacLeod RM, Kimura H, Login I: Inhibition of prolactin by dopamine and piribedit (ET-495), in Pecile A, Miller EE (Editors): *Growth Hormone and Related Peptides*. Elsevier, New York, 1976, pp 443-453.

7. Leblanc H, Lachelin GCL, Abu-Fadil S, et al: Effects of dopamine infusion on pituitary hormone secretion in humans. *J Clin Endocrinol Metab* 43:668-674, 1976.

8. Yen SSC: Physiology of Human Prolactin, in Yen SSC, Jaffe RB: *Reproductive Endocrinology*. Saunders, Philadelphia, 1978, pp 152-170.

9. Magrini GT, Ebner JR, Burckhardt P, et al: Study of the relationship between plasma prolactin levels and androgen metabolism in man. *J Clin Endocrinol Metab* 43:944-947, 1976.

10. Spark RF, White RA, Connolly PB: Impotence is not always psychogenic. *JAMA* 243:750-755, 1980.

11. Richards JS, Williams JJ: Luteal cell receptor content for prolactin (PRL) and luteinizing hormone (LH): Regulation by PRL and LH. *Endocrinol* 99:1571-1581, 1976.

12. McNatty KP, Sawers R, McNeilly AS: A possible role for prolactin in control of steroid secretion by the human graafian follicle. *Nature* 250:653-655, 1974.

13. Lyons WR, Li CH, Johnson RE: The hormonal control of mammary growth and lactation. *Rec Progr Horm Res* 14:219-254, 1958.

14. Kleinberg DL, Noel GL, Frantz AG: Galactorrhea: A study of 235 cases, including 48 with pituitary tumors. *N Engl J Med* 296:589-600, 1977.

15. Horrobin DF: *Prolactin*, Vol 5. Eden Press, Montreal, Canada, 1977.

16. Maslar IA, Riddick DH: Prolactin production by human endometrium during the normal menstrual cycle. *Am J Obstet Gynecol* 135:751-754, 1979.

17. Tyson JE, Hwang P, Guyda H, et al: Studies of prolactin secretion in human pregnancy. *Am J Obstet Gynecol* 113:14-20, 1972.

18. Smithline F, Sherman L, Kolodny HD: Prolactin and breast carcinoma. *N Engl J Med* 292:784-792, 1975.

19. Frantz AG, Kleinberg DL, Noel GL: Studies in prolactin on

man. *Rec Progr Horm Res* 28:527-590, 1972.

20. May PB, Burrow GN, Kayne RD, et al: Hypoglycemia-induced prolactin release. *Arch Intern Med* 138:918-920, 1978.

21. Noel GL, Suh HK, Frantz AG: Prolactin release during nursing and breast stimulation in postpartum and nonpostpartum subjects. *J Clin Endocrinol Metab* 38:413-423, 1974.

22. Cooke I, Foley M, Lenton E, et al: The treatment of puerperal lactation with bromocryptine. *Postgrad Med J* 52(Suppl 1):75-80, 1976.

23. Malarkey WB, Johnson TC: Pituitary tumors and hyperprolactinemia. *Arch Intern Med* 136:40-44, 1976.

24. Buckman MT, Peake GT: Prolactin in clinical practice. *JAMA* 236:871-874, 1976.

25. Kemmann E, Jones JR: Hyperprolactinemia and primary amenorrhea. *Obstet Gynecol* 54:692-694, 1979.

26. Jones JR, Gentile G: Incidence of galactorrhea in ovulatory and anovulatory females. *Obstet Gynecol* 45:13-14, 1975.

27. Urban JA, Egeli RA: Non-lactational nipple discharge. *Cancer* 28:130-140, 1978.

28. Keye WR, Chang RJ, Jaffe RB: Prolactin secreting pituitary adenomas in women with amenorrhea or galactorrhea. *Obstet Gynecol Surv* 32:727-738, 1977.

29. Chang RJ, Keye WR, Young JR, et al: Detection, evaluation, and treatment of pituitary microadenomas in patient with galactorrhea and amenorrhea. *Am J Obstet Gynecol* 128:356-363, 1977.

30. Wiebe RH, Hammond CB, Borchert LG: Diagnosis of prolactin-secreting pituitary microadenoma. *Am J Obstet Gynecol* 126:993-996, 1976.

31. Vezina JC, Sutton TJ: Prolactin-secreting pituitary microadenomas: Roentgenologic diagnosis. *Am J Roentigenol* 120:46-54, 1974.

32. Speroff L, Levin RM, Haning RV Jr, et al: A practical approach for the evaluation of women with abnormal polytomography or elevated prolactin levels. *Am J Obstet Gynecol* 135:896-904, 1979.

33. Vaughn TC, Haney AF, Wiebe RH, et al: Spontaneous regression of prolactin-producing pituitary adenomas. *Am J Obstet Gynecol* (in press).

34. Costello RT: Subclinical adenoma of the pituitary gland. *Am J Pathol* 12:205-216, 1936.

35. Schaison G, Metzger J: The primary empty sella. An endocrine study on 12 cases. *Acta Endocrinol* 83:483-492, 1976.

36. Carlsson A, Lindquist M: Effect of chlorpromazine or haloperidol on formation of 3-methoxytyramine and normetanephrine in mouse brain. *Acta Pharmacol* 20:140-143, 1963.

37. Greenblatt RB, Carmona N, Hagler WS: Chiari-Frommel Syndrome. *Obstet Gynecol* 7:165-170, 1956.

38. Argonz J, Del Castillo EB: A syndrome characterized by estrogenic insufficiency, galactorrhea and decreased urinary gonadotropins. *J Clin Endocrinol* 13:79-87, 1953.

39. March CM, Mishell DR Jr, Kletzky OA, et al: Galactorrhea and pituitary tumors in postpill and non-postpill secondary amenorrhea. *Am J Obstet Gynecol* 134:45-48, 1979.

40. Sherman BM, Harris CE, Schlechte J, et al: Pathogenesis of prolactin-secreting pituitary adenomas. *Lancet* 2:1019-1021, 1978.

41. Edwards CRW, Forsyth IA, Besser GM: Amenorrhea, galactorrhea and primary hypothyroidism with high circulating levels of prolactin. *Br Med J* 3:462-464, 1971.

42. Ramirez G, O'Neill WM, Bloomer A, et al: Abnormalities in the regulation of prolactin in patients with chronic renal failure. *J Clin Endocrinol Metab* 45:658-661, 1977.

43. Morley JE, Dawson M, Hodgkinson H, et al: Galactorrhea and hyperprolactinemia associated with chest wall injury. *J Clin Endocrinol Metab* 45:931-935, 1977.

44. Hardy J: Transphenoidal surgery of hypersecreting pituitary tumors, in Kohler PO, Ross GT (Editors): *Diagnosis and Treatment of Pituitary Tumors*. Excerpta Medica, Amsterdam, Netherlands, 1973, pp 179-194.

45. Kurnick JE, Hartmann CR, Lufkin EG, et al: Abnormal sella turcica. *Arch Intern Med* 137:111-117, 1977.

46. Jewelewicz R, VandeWiele RL: Clinical course and outcome of pregnancy in 25 patients with pituitary microadenomas. *Am J Obstet Gynecol* 136:339-343, 1980.

47. Cuellar FG: Bromocryptine mesylate (Parlodel®) in the management of amenorrhea/galactorrhea associated with hyperprolactinemia. *Obstet Gynecol* 55:278-284, 1980.

48. Thorner MO, Besser GM, Jones A, et al: Bromocryptine treatment of female infertility: Report of 13 pregnancies. *Br Med J* 4:694-697, 1975.

Diuretic Therapy

ROBERT DODELSON, M.D., East Brunswick, RICHARD SHERMAN, M.D., Westfield
NANCY E. GARY, M.D., ROBERT P. EISINGER, M.D., Piscataway*

From the proximal tubule to the collecting duct the structure and function of the tubular cells vary widely. Diuretics differ in the ways in which they modify salt and water handling by the nephron. Clinical indications and some side effects are reviewed.

Diuretics are a class of drugs that act directly on the kidney to inhibit the reabsorption of salt and water with a resultant increase in urine volume and solute excretion. In appropriate clinical settings these are desirable and efficacious results but they may be associated with undesirable side effects. The purpose of this paper is to review the mechanisms and sites of action of some of the commonly used diuretics, to describe the clinical situation where these agents are of proven value, and briefly to outline some of the unwanted results of therapy.

HANDLING OF SALT AND WATER BY THE KIDNEY

After the plasma is filtered through the glomerular capillaries, the filtrate's composition is modified during its passage through the tubules. There is active reabsorption of sodium in the proximal tubule with water following passively maintaining isotonicity; hence, as fluid enters the descending limb of the loop of Henle approximately 70 percent of the salt and water has been reabsorbed.

The epithelial layer of the descending limb is impermeable to salt but not to water. The result is a hypertonic filtrate with a high concentration of sodium chloride at the end of the loop. The ascending limb of the loop of Henle can be divided into two parts anatomically and functionally. Just beyond the tip of the loop the epithelial lining is quite thin, but as the loop approaches the renal cortex the epithelium thickens. In this thick portion chloride is reabsorbed actively

and sodium follows passively. The ascending limb is relatively impermeable to water so that the fluid reaching the distal tubule is dilute, hence the term "diluting segment" applies to this part of the nephron.

In the distal tubule salt continues to be reabsorbed with sodium becoming the ion that is transported actively. Finally the fluid reenters the medulla where the collecting ducts are to be found. The collecting ducts are either water permeable or impermeable depending on the presence or absence of antidiuretic hormone. Sodium also is transported actively here, and changes in this terminal nephron segment can influence the final composition of the urine in an important way. The glomerular filtrate, typically with more than 90 percent of its salt and water reabsorbed, then enters the renal pelvis as urine.

SITE OF ACTION OF DIURETICS

The proximal tubule actively reabsorbs 90 percent of the filtered bicarbonate facilitated by the enzyme carbonic anhydrase. This enzyme is inhibited by the diuretic acetazolamide with resultant bicarbonaturia and natriuresis. Because acidosis inhibits the diuretic action of acetazolamide, its effect tends to be self-limited. The drug

*Dr. Dodelson is Clinical Associate Professor, Dr. Sherman is Assistant Professor, Dr. Gary is Associate Professor and Dr. Eisinger is Professor, Department of Medicine, Rutgers Medical School, CMDNJ. Correspondence may be addressed to Dr. Dodelson at 15 West Prospect Street, East Brunswick, NJ 08816.

Table Diuretics				
Class	Generic Name	Trade Name(s)	Daily Dose	Indications
Carbonic Anhydrase Inhibitors	Acetazolamide	Diamox	*250-1000 mg	glaucoma, epilepsy, edema
Thiazide & Thiazide-Like	Hydrochlorothiazide	Hydrodiuril, Esidrix, Oretic	50-200 mg	edema, hypertension, *hypercalciuria, *nephrogenic diabetes insipidus
	Chlorothiazide	Diuril	500-2000 mg	
	Chlorthalidone	Hygroton	25-200 mg	
	Cyclothiazide	Anjydron	0.5-6 mg	
	Methyclothiazide	Aquatensin, Enduron	2.5-10 mg	
	Hydroflumethiazide	Diucardin, Saluron	25-200 mg	
	Benzthiazide	Exna	50-200 mg	
	Trichlormethiazide	Metahydrin, Naqua	2-8 mg	
	Bendroflumethiazide	Naturetin	2.5-20 mg	
	Polythiazide	Renese	1-4 mg	
	Quinethazone	Hydromox	50-200 mg	
"Loop" Diuretics	Furosemide	Lasix	20-600 mg	edema, hypertension, pulmonary edema *hypercalcemia
	Ethacrynic Acid	Edecrin	25-400 mg	edema, pulmonary edema
Distal Tubule	Spironolactone	Aldactone	25-200 mg	edema, hypertension, hypokalemia, primary hyperaldosteronism
	Triamterene	Dyrenium	50-300 mg	edema, hypokalemia
Mercurials	Mercaptopimerin	Thiomerin	25-250 mg SQ or IM	edema
Osmotic	Mannitol	--	50-200 gm IV	oliguria
Osmotic	Metolazone	Zaroxolyn, Diulo	2.5-20 mg	edema, hypertension
Dose for edema is 250-375 mg on alternate days not FDA approved for this indication				

main usefulness is in the treatment of glaucoma.

The potent "loop" diuretics ethacrynic acid and furosemide act primarily to inhibit active chloride reabsorption in the thick ascending limb of the loop of Henle. Thus they prevent solute from leaving the tubular lumen so the fluid entering the distal tubule is not as dilute as it is normally. Hence these drugs interfere with the kidneys' ability to excrete an extremely dilute urine. Under these circumstances, if the patient drinks large amounts of water, dilution of body fluids and hyponatremia may occur. In addition the high ambient osmolality of the medullary interstitium is altered so that these agents also prevent maximal urinary concentration.

Thiazides and metolazone act primarily on the "cortical diluting segment." They also hamper the kidneys' ability to dilute the urine but they do not dramatically diminish the ability to concentrate the urine. Metolazone may act in the proximal tubule as well.

Spironolactone is a competitive antagonist of aldosterone and acts in the distal tubule to block aldosterone-induced sodium reabsorption. Triamterene also acts in this segment but in a manner unrelated to aldosterone activity so that its effects might be additive to that of spironolactone.

SOME REMARKS ABOUT INDIVIDUAL DIURETICS

Acetazolamide will produce a hyperchloremic acidosis because of its effect on bicarbonate reabsorption. Since bicarbonate acts in the distal tubule as a relatively impermeant anion (compared to chloride), the enhanced intraluminal electronegativity stimulates potassium secretion accounting for the prominent hypokalemia seen with this drug. The drug should be used cautiously, if at all, in patients with severe renal insufficiency since it tends to aggravate the metabolic acidosis that usually already is present. In some

people (e.g., in cystinuria) it may be desirable to maintain an alkaline urine; acetazolamide in combination with bicarbonate may be of value in this setting.

Ethacrynic acid and furosemide are the most potent of the currently available diuretics. The main side effects are electrolyte abnormalities, dehydration, deafness and hypersensitivity reactions. In a few cases they have been implicated, as have thiazides, in the development of acute allergic interstitial nephritis.¹

Thiazide diuretics commonly cause hypokalemia, metabolic alkalosis and hyperuricemia. A recent article addressed itself to the question of potassium supplementation even in those patients not taking digitalis.² Holter monitoring showed increased ventricular ectopic activity in many of those receiving the drug. There is no evidence that diuretic-induced hyperuricemia should be treated in the absence of gout. Adverse reactions to thiazides include carbohydrate intolerance, hyponatremia, pancreatitis, hyperlipidemia and bone marrow suppression. An association between thiazide usage and acute cholecystitis has been asserted and denied.^{3,4}

The effective use of diuretics in renal failure may present a particular problem. It generally is held that thiazides lose their efficacy when the glomerular filtration rate falls below 30cc/minute though this concept has been challenged by Bank.⁵ Ethacrynic acid and furosemide are often effective (albeit with increased dosage) even with markedly impaired renal function. Increased urinary volume and solute excretion have been reported in patients with creatinine clearance as low as one ml/minute.

Metolazone appears to have greater potency than the thiazides but is weaker in its action than the loop diuretics. With larger doses (up to 150 mg a day) than normal (2.5 to 10 mg a day) Dargie was able to initiate a diuresis in severely

azotemic patients (creatinine clearances of 1.2 to 12 ml/minute).⁶

Spironolactone works best in situations of aldosterone excess. This would include primary aldosteronism and states with marked secondary aldosteronism, such as cirrhosis of the liver. It is most effective when combined with diuretics acting more proximally in the nephron (e.g., thiazides or furosemide). Once the creatinine clearance falls below 25 ml/minute the drug should not be used because of its lack of efficacy and enhanced potential for causing hyperkalemia. The action of spironolactone can be blunted by taking aspirin.⁷ An unusual side effect of this drug is gynecomastia and, as with some of the other diuretics, impotence may occasionally be a troublesome complication.

As with spironolactone, triamterene also should be avoided in patients with low glomerular filtration rates because of the danger of hyperkalemia. Ettinger has found triamterene present in the nucleus of renal stones in a small number of patients taking the drug in recommended dosages.⁸

USE OF DIURETICS IN NON-EDEMATOUS STATES

The thiazides have been used with some success in patients with nephrogenic diabetes insipidus. Drug-induced plasma volume contraction increases water reabsorption in the proximal tubule and decreases water delivery to the functionally impaired distal portion of the nephron. This results in a diminished urine volume. Salt restriction also should be advised when the drug is used for this purpose. In addition thiazides decrease urinary calcium excretion and may be useful therapeutic agents in recurrent calcium stone formers with hypercalciuria.⁹

In acute hypercalcemic states furosemide (along with

saline administration) frequently will increase urinary calcium excretion and lower serum calcium. Furosemide also has been used extensively in oliguric patients in an attempt to initiate a diuresis and in hopes of preventing development of acute renal failure. Unfortunately it is not uniformly effective. Increasing urinary output in oliguric patients is advantageous since the need for dialysis may be lessened.

The most common nonedematous situation where diuretics are used is in the treatment of hypertension. The choice of agent rests with the clinician but care should be taken to monitor the electrolyte status.

REFERENCES

1. Lyons H, Pinn VW, Cortell S, Cohen JJ, Harrington JT: Allergic interstitial nephritis causing reversible renal failure in four patients with idiopathic nephrotic syndrome. *N Engl J Med* 288:124-128, 1973.
2. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 70:762-768, 1981.
3. Rosenberg L, Shapire S, Slone D, Kaufman DW, Miettinen OS, Stolley PD: Thiazides and acute cholecystitis. *N Engl J Med* 303:546-548, 1980.
4. Porter JB, Jick H, Dinan BJ: Acute cholecystitis and thiazides. *N Engl J Med* 304:954-955, 1981.
5. Bank N, Lief PD, Piczon O: Use of diuretics in treatment of hypertension secondary to renal disease. *Arch Intern Med* 138:1524-1529, 1978.
6. Dargie HJ, Allison MEM, Kennedy AC, Gray MJB: High dosage metolazone in chronic renal failure. *Br Med J* 4:196-198, 1972.
7. Tweeddale MG, Ogilvie RI: Antagonism of spironolactone-induced natriuresis by aspirin in man. *N Engl J Med* 289:198-200, 1973.
8. Ettinger B, Oldroyd NO, Sörgel F: Triamterene nephrolithiasis. *JAMA* 244:2443-2444, 1980.

Bilateral Synchronous Primary Lung Cancer*

JACK GOLDSHLACK, D.O. and BENJAMIN H. SAFIRSTEIN, M.D., Newark

A case is presented exemplifying criteria for diagnosis of simultaneous multiple primary bronchogenic carcinomas, staging of the tumors, and the decision process for their surgical removal. While this is a rare occurrence, simultaneous primary carcinoma should be considered as surgical removal offers a chance for prolonged survival.

Bilateral synchronous primary carcinoma of the lung is rarely diagnosed during life.¹⁻⁴ Its occurrence poses difficult diagnostic and therapeutic problems. This report documents such an occurrence and discusses its management.

CASE REPORT

A 58-year-old female complained to her physician of cough, fatigue, weight loss, symmetrical ankle edema and wrist pain. She had smoked two packs of cigarettes daily for over 30 years and had a chronic cough, which became productive of blood-tinged sputum over the previous months. Review of systems was otherwise unremarkable.

Physical examination revealed a thin, chronically-ill appearing female. Examination of the thorax was unremarkable. No lymphadenopathy was present. Auscultation and percussion of the chest were negative. Breast examination demonstrated no masses. She had bilateral clubbing of the fingers and toes. The remainder of the physical examination was normal. A chest radiograph (Figure 1) demonstrated bilateral pulmonary infiltrates with a 5×7 cm homogeneous density with central cavitation in the right lower lobe and a 3×3 cm homogeneous density in the left upper lobe. There was no hilar enlargement. The heart was

normal size. Laboratory evaluation revealed a hemoglobin of 14 g/dl; the white cell count was 7,400 and an alkaline phosphatase was 11 B.U. Sputum cytology on six occasions was negative for malignants cells. A barium enema and intravenous pyelogram were normal.

Fiberoptic bronchoscopy demonstrated endobronchial obstruction of the right lower lobe (RLL) but no endobronchial abnormality in the left upper lobe. Brush biopsy from the RLL was compatible with adenocarcinoma. Bronchial biopsy and washing of the left upper lobe were normal. CT scan of the thorax (Figures 2 and 3) demonstrated bilateral mass lesions. No evidence of hilar lymph node enlargement was seen. Preoperative pulmonary function studies demonstrated a FVC of 90 percent of predicted.

Mediastinoscopy and lymph node biopsy were normal. A thoracotomy using a median sternotomy revealed a 5×5 cm cavitory adenocarcinoma of the RLL. All right hilar nodes removed were normal. A right lower lobectomy was performed. The surgeon also found a 3×5 cm large-cell undifferentiated carcinoma in the left upper lobe. All left hilar nodes removed were normal. A left upper lobectomy was performed.

One month following discharge, finger clubbing subsided. By thirteen months postoperatively, the patient had gained 22 pounds. Repeated chest x-ray has shown no recurrence of tumor. The patient had no complaints.

PATHOLOGY

The right lower lobe consisted of 260 gms of tissue with a

*This report is from the Department of Pulmonary Medicine, St. Michael's Medical Center, Newark. Drs. Goldshlack and Safirstein may be addressed there, 268 High Street, Newark 07102.



Figure 1—Chest radiograph demonstrated a cavitary mass in the right lower lobe and an homogeneous mass density in the left upper lobe.

smooth glistening pleural surface. Slight retraction at the anterior margin was present. The cut surfaces were finely granular and showed extensive areas of softening hemorrhage and cystic degeneration in its center. Microscopic examination revealed adenocarcinoma (Figure 4).

The left upper lobe revealed a retracted pleural surface and a lobulated tumor measuring 3 x 5 cm, firm in nature and tannish-yellow in color. There was no association with a major bronchus. Microscopic examination (Figure 5) of the tumor consisted of large cell undifferentiated carcinoma.

DISCUSSION

Carcinoma of the lung is one of the most common tumors in adults, but the incidence of multiple primary bronchogenic carcinoma is exceedingly low. Bilateral synchronous primary carcinoma of the lung occurred in two of 2664 cases of lung cancer reported by Razzuk *et al*¹ and in only four of 5163 cases reported by Martini and Melamed.²

Certain criteria must be fulfilled before dual pulmonary tumors can be considered separate primary neoplasms.^{1,3} Each tumor must have distinctly different histologic features and occur in different anatomic regions of the lung. Simultaneous appearance, similar size, and the absence of any extrapulmonary primary malignancy strongly suggest primary origin within the lung. If metastases are present, they must maintain the histologic pattern of the primary neoplasms.

In the management of our patient, we were careful to exclude extrapulmonary primary carcinoma with metastasis to the lung, as well as other unusual entities such as Wegener's granulomatosis, lymphoma and multiple pulmonary infarction, which can appear as bilateral mass lesions. There is a tendency to assume that the presence of two masses in different areas of the lung represent hopeless

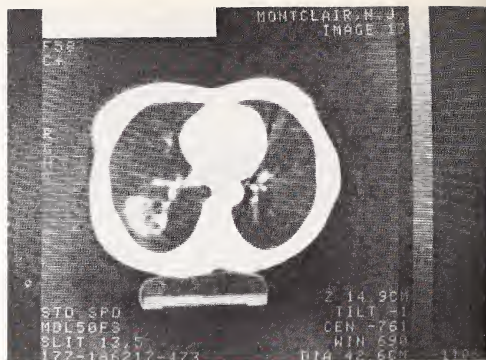


Figure 2—Computerized tomographic scan of the chest demonstrated a well-circumscribed cavitary mass with no pleural involvement of hilar adenopathy.

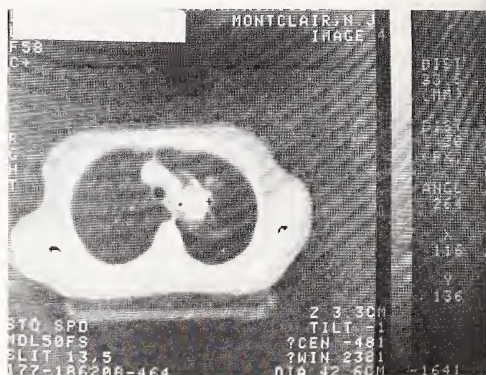


Figure 3—Computerized tomographic scan of the upper thorax demonstrated a mass density situated in the anterior segment of the left upper lobe and free of pleural involvement.

metastatic malignant disease. However, if separate primary tumors can be demonstrated, bilateral surgical resection offers a chance for survival.^{3,5} Struve-Christiansen⁴ recorded four cases of bilateral resection; in one of the four simultaneous resections were performed, while the others were staged resections. We elected bilateral simultaneous resections to prevent additional tumor growth during the period between sequential resections and to avoid additional risk of two operations and a prolonged convalescent period.

The postoperative period was uncomplicated, aside from pain, well tolerated. At thoracotomy there was no tumor involving hilar nodes, pleura or pericarditis.

SUMMARY

A case has been presented exemplifying criteria for diagnosis of simultaneous multiple primary bronchogenic carcinomas, staging of the tumors, and the decision process for their surgical removal. While this is a rare occurrence, simultaneous primary carcinoma should be considered as surgical removal offers a chance for prolonged survival.

REFERENCES

1. Razzuk MA, Pockey M, Vrsched HC, Paulson DL: Dual primary bronchogenic carcinoma. *Ann Thorac Surg* 17:425-433, 1974.

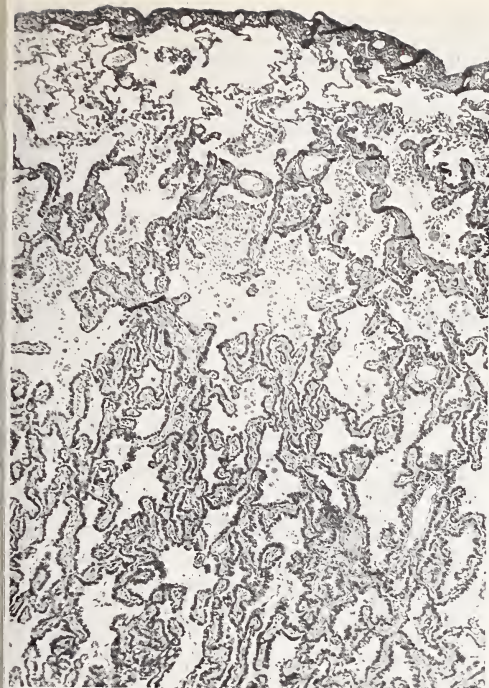


Figure 4—Hematoxylin-eosin stain of a section from the right lower lobe consisted of an adenocarcinoma with mucin production.

2. Martini N, Melamed M: Multiple primary lung cancers. *J Thorac Cardiovas Surg* 70:606-612, 1975.
3. Soorae A, Ajaib S.: Staged bilateral lobectomy for synchronous bilateral squamous cell carcinoma of lung. *Thorax* 33:

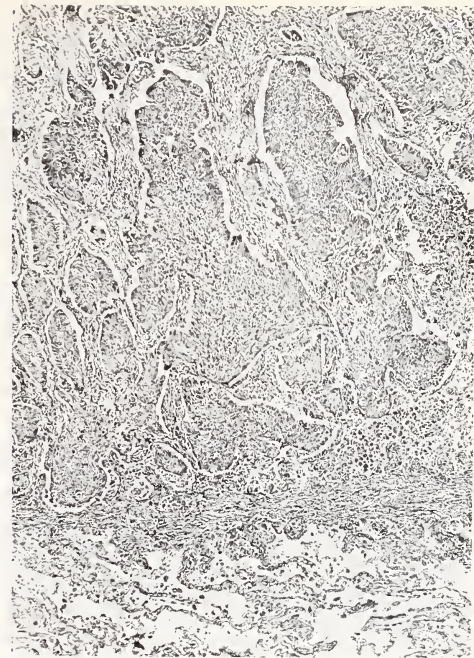


Figure 5—Hematoxylin-eosin section (44X) from the left upper lobe demonstrated a large cell undifferentiated carcinoma.

511-513, 1978.

4. Struve-Christiansen E: Diagnosis and treatment of bilateral primary bronchogenic carcinoma. *J Thorac Cardiovas Surg* 61: 501, 1971.
5. Caceres J, Felson B: Double primary carcinomas of the lung. *Radiol* 102: 45, 1972.

Giant Left Atrium With Massive Mural Thrombus in a Patient With Mitral Stenosis*

NICHOLAS L. DEPACE, M.D., ALBERTO ELGUEZABAL, M.D.,
MORRIS N. KOTLER, M.D., BERNARD WAGNER, M.D., Philadelphia

A giant left atrium in a patient with pure chronic mitral stenosis is described. Although unusual, giant left atrium is almost always the result of rheumatic mitral valve disease, either insufficiency, stenosis or both. The long duration, stable course and unique pathological changes reflect on the unusual ability of the heart to respond to anatomical distortion.

Increase in left atrial size may be present in association with many cardiac diseases such as hypertension, aortic valvular disease, congestive heart failure from any cause,¹ complete heart block² and a variety of congenital defects. Atrial enlargement in these conditions, however, is usually not of striking proportions. Enlargement of the left atrium is well known as one of the earliest manifestations of rheumatic mitral valvular dysfunction.

The first instance of left atrial enlargement was reported by Owen and Fenton in 1901.³ Postmortem revealed severe mitral insufficiency and a giant left atrium containing 900 ml of blood (normal content is less than 40 ml of blood). Giant left atria usually are seen when the major lesion is mitral regurgitation.^{4,5} Although enlarged left atria have been documented with pure mitral stenosis,^{6,7} it is not clear that the atrial enlargement in such cases ever approaches the proportions seen in patients with mitral insufficiency.^{4,8}

Our patient had long-standing pure mitral stenosis with massive left atrial enlargement. The chronic, stable course of this patient and the unusual pathological features reflect on the adaptability of the heart to unique anatomical alterations.

CASE REPORT

A 74-year-old female was admitted to the hospital for episodes of left arm weakness and dizziness.

At age 19, the patient had a clinically documented episode

of rheumatic fever. The patient was edematous and pre-eclamptic at age 27 during her first pregnancy and was temporarily treated with digitalis. Fatigue and shortness of breath developed at age 42. Atrial fibrillation was noted and, the patient was redigitalized. At age 56 peripheral edema and pulmonary congestion became manifest. She had clinical findings compatible with mitral stenosis, including a loud first heart sound, sharp early opening snap along the left sternal border and a long diastolic rumble at the apex. Chest x-ray showed a markedly dilated heart with a cardiac thoracic ratio of 20:29.7. The cardiac enlargement was thought to represent a predominate left atrium. Cardiac catheterization showed pulmonary artery pressure of 36/14 mm Hg, pulmonary capillary wedge of 14 mm and end diastolic mitral valve gradient of six with the mitral valve orifice calculated to be 1.5 cm² and a cardiac output of 3.5 L./minute.

The patient did well on medical therapy for 16 years with

*From the Departments of Internal Medicine (Dr. DePace), and Pathology (Dr. Elguezabal and Dr. Wagner), Overlook Hospital, Summit, New Jersey; and Department of Pathology, Columbia College of Physicians and Surgeons, New York (Dr. Elguezabal and Dr. Wagner). Dr. DePace is now Chief Medical Resident with the Department of Internal Medicine, Hahnemann Hospital, Philadelphia. Dr. Kotler is Director of the Cardiovascular Noninvasive Laboratory, Hahnemann Hospital, Philadelphia. Correspondence may be addressed to Dr. DePace, c/o Dr. Kotler, at the Likoff Cardiovascular Institute, Hahnemann Medical College and Hospital, 230 North Broad Street, Philadelphia, Pa. 19102.

two embolic events associated with transient hemiparesis. She underwent cardiac catheterization following an episode of pulmonary edema two years prior to admission. Her pulmonary pressures were relatively unchanged; pulmonary artery pressure 43/13 mm Hg, pulmonary capillary wedge 17 mm Hg, cardiac output 2.4 liters/minute and mitral valve orifice now critically narrowed to 0.5 cm² with a mean valve gradient of 14.2 mm. There was enormous enlargement of the left atrium with significant calcification. Operative mitral valve replacement was not recommended because of the patient's age and family reluctance.

The patient's final hospital admission was for left arm weakness and dizziness. She had no speech changes, difficulty with gait or headache. On physical examination she was in no acute distress. Pulse was 80 and irregular and blood pressure was 170/84. Examination of the head and neck was unremarkable. The point of maximal cardiac impulse was in the sixth intercostal space, midclavicular line. The first heart sound was accentuated. A grade one over six soft systolic murmur along the left sternal border was appreciated. A loud opening snap, 0.12 seconds after the second heart sound, ushered in a long diastolic rumble, which was confirmed on phonocardiography. The second heart sound was not accentuated. The lungs were clear. Neurological examination revealed only a left arm drift.

Chest x-ray showed severe cardiac enlargement and a massive calcified left atrium. Echocardiogram showed reduced E-F slope with increased echoes of mitral leaflet compatible with mitral stenosis. The left atrium was enlarged but true endocardium of the posterior wall was difficult to

visualize because of intracavitary echoes. Electrocardiogram showed right axis deviation and slow junctional rhythm. Digitalis was withheld. The patient became comatose; she was transferred to the intensive care unit and expired shortly thereafter.

Autopsy revealed that the pericardial sac was totally obliterated by fibrous adhesions. The enormous cardiac enlargement was due entirely to massive left atrial dilatation. The right atrium was of average size but was compressed by the interatrial septum bulging to the right. The vena cavae were of normal caliber with compression of the superior vena cava. The tricuspid valve was unremarkable and measured 13.2 cm in circumference. The right ventricle showed hypertrophy measuring 0.6 cm in thickness and the cavity was of average size. The pulmonary valve measured 7.7 cm in circumference and was unremarkable. The left atrium was huge (Figures 1a and 1b) measuring 17 x 14 x 14 cm. It was ovoidal shape, solid, with extensive calcified areas (Figure 1a on x-ray specimen). The lumen was filled by massive organizing thrombus (Figure 1b) except in one irregular corridor, a space running from the base toward the mitral valve. The thrombus was firmly adherent to the atrial wall in several broad areas especially in the calcified parts and easily detachable in the rest of the atrium. The auricular appendage was occupied by adherent thrombus. The auricular wall was paper thin and smooth in non-calcified areas. Histologically the muscular wall was replaced by thick bands of fibrous tissue and only few atrophic and fibrotic muscle bundles could be recognized. Where there was no calcification or adherent thrombus, the pulmonary veins showed intimal



Figure 1A—X-ray of postmortem specimen. White arrow points to area of linear calcification in left atrium.

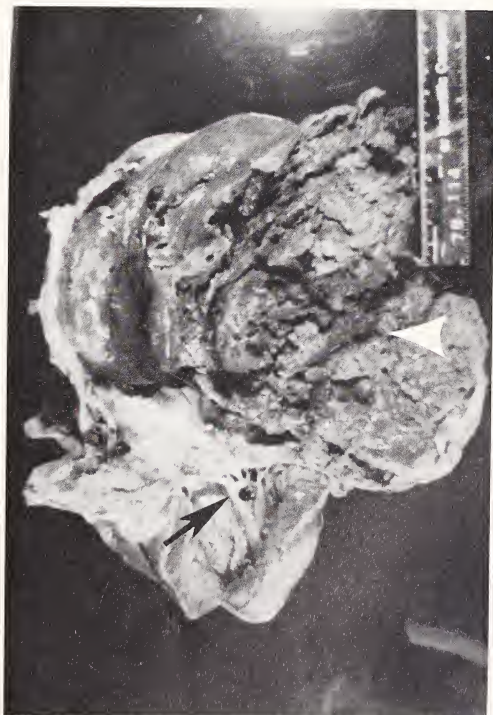


Figure 1B—Autopsy specimen. Black arrow points to mitral valve. White arrow head demonstrates massive premortem thrombus in giant left atrium.

thickening.

The mitral valve measured 6.0 cm in circumference and had the gross and histologic landmarks attributed to healed rheumatic mitral valvulitis with fusion of commissures, shortening, fusion and thickening of the chordae and fibrosis, thickening, and calcification of the leaflets. One was unable to insert the tip of the left fifth finger through the mitral valve. There was no sign of mitral insufficiency. The left ventricle was not hypertrophied (1.5 cm thickness) and recent (2 to 3 week) subendocardial infarct involving the anterior wall of the left ventricle located at the apex was present measuring 3 x 3 cm. No mural thrombus was evident. The aortic valve measured 7.1 cm and the cusps were grossly unremarkable.

The coronary arteries were moderately sclerotic but no occlusions were detected. The pulmonary arterial system showed moderate to marked atherosclerosis with obvious yellow subintimal plaques in the larger branches. The lungs showed changes of bilateral chronic and acute congestion with interstitial fibrosis and emphysematous changes. Examination of the brain showed one-week-old multifocal infarcts involving the cerebral hemispheres, basal ganglia, internal capsule, occipital lobe and pons. The cause of death was related to both congestive heart failure and cerebral infarctions, probably on an embolic basis from the left atrial thrombus.

DISCUSSION

This case of pure mitral stenosis with giant left atrium and thrombus is remarkable in that the patient's course was relatively benign over two decades. However, many authors have been impressed by the unusually good prognosis of those patients with mitral valve disease who develop aneurysmal dilatation of the left atrium. This benign clinical course is due to the failure of development of hypertensive pulmonary vascular disease.⁹ In mitral insufficiency, Braunwald observed the discrepancy between left atrial size and pressure and reasoned this reflected a disturbance in the compliance of the left atrial wall.¹⁰ Likewise, DeSanctis noted that despite the enormous size of the heart in his series of giant left atria secondary to mitral insufficiency, many of which appeared to occupy fully 50 to 75 percent of the thoracic cavity, the patients were remarkably well due to the infrequent occurrence of significant pulmonary hypertension.⁴ Heath and Best reported on cases of pure mitral stenosis with large left atria.⁶ Only two of seven showed increased medial thickness in the muscular pulmonary arteries again demonstrating that the extreme dilatation of the left atrium was associated with a failure to develop hypertensive pulmonary vascular disease. The authors also concluded that neither mitral incompetence nor left ventricular hypertrophy appears to be necessary for the development of aneurysmal dilatation of the left atrium.

Our case illustrates this point because no left ventricular hypertrophy or mitral insufficiency (which is not possible to demonstrate at autopsy with this much atrial disease) was demonstrated clinically or at autopsy. The typical findings of rheumatic mitral regurgitation, which were absent in this case, are foreshortening of the chordae tendinae together with thickening and eversion of the leaflets which suggest improper coaptation and mitral regurgitation. It is of interest to note that Wood found that cases of mitral stenosis with very high pulmonary vascular resistance had slight dilatation of the left atrium.¹¹

The entire left atrium was involved with a mural thrombus in the present case. This was the presumed origin of the multiple cerebral emboli demonstrated at autopsy. In the series of Heath and Best, two cases of pure mitral stenosis had a thrombus filling much of the cavity of the dilated left atria at necropsy.⁶ In these cases the right ventricle was hypertrophied whereas it was hypertrophied in only one of the two remaining five patients with pure mitral stenosis and no thrombus. It was postulated that the cavity of the dilated chamber had been secondarily reduced in size by antemortem thrombus. Our patient also had right ventricular hypertrophy (0.6 cm in thickness, normal less than 0.5 cm) with an accompanying large antemortem thrombus. DeSanctis commented on the rarity of systemic emboli with mitral insufficiency.⁴ In his series of ten patients with massive left atria no thrombus formation was found. A likely explanation is that significant mitral insufficiency produces enough turbulence in the left atrial reservoir to prevent thrombus formation.

Extreme bilateral atriomegaly is occasionally observed in rheumatic heart disease. There is always either rheumatic tricuspid insufficiency or tricuspid incompetence due to stretching of the tricuspid ring in chronic right heart failure.⁵ No right atrial enlargement or tricuspid insufficiency was noted at autopsy in our case. Patients with pure mitral stenosis, normal-sized left atria and giant right atria have been described.¹² In these patients, calcification of the left atrium, probably the result of organization of thrombus, was found. It was felt that the calcific deposits prevented the left atria from dilating. All patients had tricuspid regurgitation.¹² Our patient had calcium throughout the left atrium which obviously did little to restrain the enlarged left atrium but probably formed in the organizing thrombus. The echocardiogram significantly underestimated the size of the left atrium, which when enlarging takes the pathway of least resistance, namely rightward and superior.⁴ One must be careful in interpreting echocardiographic dimensions in patients with giant atria in which thrombus is present because the endocardium of the posterior atrial wall may not be discernible if multiple echoes representing thrombus are present.

Nearly all patients with enormous left atria have histories

"This case of pure mitral stenosis with giant left atrium and thrombus is remarkable in that the patient's course was relatively benign over two decades."

"... neither mitral incompetence nor left ventricular hypertrophy appear to be necessary for the development of aneurysmal dilatation of the left atrium."

of acute rheumatic fever or chorea and it has been suggested that they have more severe attacks of one or more relapses of acute rheumatic fever than patients with similar valvular lesions and less left atrial dilatation.¹² Our patient had at least one reported attack of rheumatic fever and an exacerbation of rheumatic heart disease during pregnancy. In the face of giant left atria and mitral valve disease, the etiology is rheumatic if a congenital cause is excluded even if no history of prior rheumatic fever is obtained.⁴

It is interesting that our patient had a long aortic second sound (A_2) to opening snap (OS) interval of 0.12 seconds. Although a short A_2 —OS interval is a reliable indicator of severe stenosis, the converse is not true.¹³ The large compliant left atrium protected the pulmonary vasculature producing a lower left atrial pressure than expected from such a reduced mitral valve orifice. In addition, a prolonged A_2 —OS interval may be seen in the presence of valvular calcification since the time interval between the actual opening of the mitral valve and OS is prolonged.¹⁴

Most patients with mitral stenosis have high left atrial pressures which are transmitted to the pulmonary arteries and cause right ventricular dilatation. In contrast mitral regurgitation is a volume overload situation in which the atria enlarge and stretch losing their compliance but protecting the pulmonary vasculature from transmission at high pressures. The extreme atriomegaly in our case may have been due to accompanying healed atrial myocarditis, and thrombus formation was probably secondary to stagnation of blood in the large atrial cavity. However, thrombus formation may lead to further obstruction of the mitral valve with progressive left atrial enlargement in these particular cases resulting in a vicious circle.

SUMMARY

A case of long-standing pure mitral stenosis is presented. The patient's long and indolent course is compatible with a large compliant atrial reservoir which prevented the rapid

onset of pulmonary hypertension. Although a rare entity today, giant left atrium is usually a reflection of mitral rheumatic heart disease and may be caused by significant mitral insufficiency, combined insufficiency and stenosis, or as in the present case, pure mitral stenosis.

REFERENCES

1. Cobbs BW, Shillingford JP, Steiner RE: The size of the left atrium in conditioning other than mitral valve disease. *Br Heart J* 19:495, 1957.
2. Peel AAF: Dilatation of the auricles resulting from heart block and producing pressure symptoms. *Lancet* 2:1248, 1929.
3. Owen IO, Fenton WJ: A case of extreme dilatation of the left auricle of the heart. *Trans Clin Soc Lond* 34:183, 1901.
4. DeSanctis RW, Dean DC, Bland EF: Extreme left atrial enlargement: Some characteristic features. *Circulation* 29:14-23, 1964.
5. Rogers WR, Wittels B: Extreme bilateral atriomegaly: Review of the literature and report of a case. *Circulation* 15:434-441, 1957.
6. Best PV, Heath D: The right ventricle and small pulmonary arteries in aneurysmal dilatation of the left atrium. *Br Heart J* 26:312-316, 1964.
7. Kent EM, Fisher DL, Ford WB, Neville JF: Mitral valve surgery and left heart catheterization in giant left atrium. *Arch Surg* 73:503-507, 1956.
8. Case records of the Massachusetts General Hospital, No. 25, *N Engl J Med* 294:1391-1398, 1976.
9. Daley R, Franks R: Massive dilatation of the left auricle. *Quart J Med* 1:18-81, 1949.
10. Braunwald E, Awe WC: The syndrome of severe mitral regurgitation with normal left atrial pressure. *Circulation* 27:29-35, 1963.
11. Wood P: An appreciation of mitral stenosis, Part II, Investigations and results. *Br Med J* 1:1113, 1954.
12. Roberts WC, Humphries JO, Morrow AG: Giant right atrium in rheumatic mitral stenosis; atrial enlargement restricted by mural calcification. *Am Heart J* 79:28-35, 1970.
13. Braunwald E: Valvular heart disease, in *Heart Disease*. Philadelphia, Saunders, 1980, p. 1100.
14. Kalmanson D, Veyrat C, Barnier A, Witchitz S, Chiche P: Opening snap and ischemic relaxation period in relation to mitral valve flow in patients with mitral stenosis: Significance of the A_2 —OS interval. *Br Heart J* 38:135, 1976.

Nineteenth Century Drug Therapy: Computer Analysis of the 1854 Prescription File of a Burlington Pharmacy

DAVID L. COWEN, M.A., LOUIS D. KING, Ph.D.,
NICHOLAS G. LORDI, Ph.D., Piscataway*

This computer study of 549 prescriptions of 1854, written mainly by three Burlington (NJ) physicians, reveals the materia medica actually used, the drugs most frequently employed (opium, ipecac, camphor, mercury) and the symptomatic and often empirical prescribing practices of the physician.

In 1850 the Medical Faculty of Harvard presented what they called "Practical Views on Medical Education." It included the following statement:

In materia medica there are some thousands of substances and their compounds, which possess what is called medicinal power. Yet it is not probable that any physician effectively reads more than one-half or remembers one-quarter, or employs in his yearly practice one-tenth of the content of the common dispensatories¹

In a manner of speaking this study seeks to put this statement to the test for it began with the realization that pharmacopoeial literature and materia medica texts do not give an accurate picture of the medications that were in actual use at a given time.

We are studying, with the aid of a computer, 19th century prescriptions and we have put into the computer 549 of the prescriptions that were pasted into the prescription book of the Allinson Pharmacy of Burlington, New Jersey between late December 1853 and March 22, 1854.² For each of these prescriptions we have recorded: Rx number, date, physician, patient's name, sex and whether adult or child, ingredients (each separately), form in which the ingredient was called for, class of the ingredient (vegetable or other), procedure required of the pharmacist, total quantity dispensed, final dosage form, whether USP, NF, or other reference or homeopathic remedy was referred to, and the directions to the patient. From this information we should be able to learn

a great deal about the practice of medicine in the mid-nineteenth century.

BURLINGTON AND THREE PHYSICIANS

Burlington is in southwestern New Jersey and was and is a satellite of Philadelphia. In 1850 there were 5,400 people in the two jurisdictions known as the city and the town of Burlington. Of the 549 prescriptions we have worked with, 493, or over 91 percent, were written by three physicians. The remainder were written by four identifiable physicians; some contained no physician identification. The major three physicians were Franklin Gauntt, who wrote 200 prescriptions, Joseph Parrish, who wrote 173, and David B. Trimble, who wrote 120. Of these the most distinguished was Joseph Parrish.

Parrish was born in 1818, the son of the noted Philadelphia physician by the same name. The son was no ordinary small-town doctor. A graduate of the University of Pennsylvania (M.D.) in 1844, he was the founder (in 1847) and editor of the *New Jersey Medical Reporter and Transactions of the New*

*Presented before the Medical History Society of New Jersey, May 20, 1981, Academy of Medicine of New Jersey, Lawrenceville. David L. Cowen is Professor Emeritus of History, Rutgers University and Lecturer in the History of Pharmacy, Rutgers College of Pharmacy; Louis D. King is Professor Emeritus of Pharmacy and Associate Dean Emeritus, Rutgers College of Pharmacy; Nicholas G. Lordi is Professor of Pharmacy and Assistant Dean, Rutgers College of Pharmacy. Mr. Cowen may be addressed at 186-C Malden Lane, Rossmoor, Jamesburg, NJ 08831.

Jersey Medical Society. In 1859 the journal stopped publishing the *Transactions* and in 1864 it moved to Philadelphia where it became the *Medical and Surgical Reporter*. In 1854—the same year as these prescriptions—he took over the chair of Obstetrics and Diseases of Women and Children at the Philadelphia College of Medicine.

We were curious to see if this prescription study could throw any light on Parrish's special qualifications for this chair. Of his prescriptions over 25 percent were for children and at least 34 percent were for women, for a total of 59 percent. Franklin Gauntt's prescriptions were only 21 percent for children and over 23 percent for women, for a total of 45 percent. That is, these admittedly fragmentary statistics might indicate that Parrish's practice was somewhat weighted toward the care of women and children. Parrish wrote prolifically and is most noted for his work on alcoholism and his insistence that it was a disease.³

Franklin Gauntt was born in Burlington in 1823. He studied under Parrish and received his M.D. degree at the University of Pennsylvania in 1847. He spent his career in Burlington and apparently gained a reputation as a surgeon. Like Parrish, he was active and prominent in county and state medical societies. Late in his career he served on the State Board of Health.⁴

Of David B. Trimble little is known. A David B. Trimble from Baltimore or Delaware received his M.D. degree from the Jefferson Medical School in 1837. Whether it was this David B. Trimble who later lived in Beverly, New Jersey and became active in the county medical society, we cannot be certain. But David B. Trimble was elected president of the county society in 1855; this surely was evidence of professional recognition.⁵

These three practitioners were as qualified and as "regular" as the times provided. Their prescriptions must, therefore, be considered as reflecting the contemporary knowledge of and practice in drug therapy, at least as practiced by those physicians who were trained in Philadelphia.

MEDICINE IN THE 1850s

What does the study so far tell us about the practice of medicine? In the first place it must be noted that the patients—there were about 250 of them who received 549 prescriptions—were more often men. Of the 479 prescriptions that could be identified in this manner 46 percent were issued to men, about 33 percent were issued to women, and 20 percent to children. The status of the remainder is unknown, but they probably were not children.

As we examine the articles prescribed, a very close relationship between them and the then current USP of 1850 becomes clear. This might be expected from Philadelphia-trained physicians, since Philadelphians played a prominent and often dominant role in compiling and revising the *Pharmacopoeia*. The 1850 USP was divided into materia medica and preparations, the former being subdivided into primary and secondary lists. The only substances prescribed that were not to be found among the itemized materia medica were bread crumbs, sheepskin, cicuta, camellia, and hydrangea. The first two are understandable omissions from the *Pharmacopoeia*, cicuta and camellia were obscure, and hydrangea was to find a place in the later dispensatory literature. Naturally the five proprietaries among the prescriptions—MacMunn's Opium, Henry's Magnesia, Hodgson's Citrate, Husband's Magnesia, Chapman's Dinner Pills, and Lee Wind Pills—were not to be found in the *Pharmacopoeia*. A few of these may suggest branded ethicals,

but it is very likely that they were all over-the-counter preparations.

There were 24 preparations that were prescribed and were not to be found in the USP. Four of these were to be found in *Dispensatory of the United States* of 1843; one, sulphate of aluminum was later to become official; the other three, effervescent powder, syrup of poppies, and infusion of senega, were derived from the *Edinburgh Pharmacopoeia*. Seven of the preparations found a place in the later literature and at least three became official. Some of these preparations and ten others that are not to be found in the 1843 *Dispensatory*, the 1850 *Pharmacopoeia* or the 1883 *Dispensatory* were probably improvisations by the physicians; virtually all were derived from ingredients that were official. The pharmacist would have little difficulty in extemporaneously making up a liniment of camphor and chloroform or an extract of lactacarium even though his *Pharmacopoeia* and *Dispensatory* might not contain them.

All of this would seem to indicate that the physician was aware of the developments in the materia medica. Four of the 17 new substances introduced into the materia medica list of the 1850 *Pharmacopoeia* were prescribed (cotton, brandy, red wine, cod liver oil), and 10 of the 53 preparations introduced were prescribed (acetic extract of colchicum, fluid extract of rhubarb, fluid extract of valerian, glycerin, powder of iron, syrup of wild cherry bark, compound tincture of cardamon, citrate of potassium, collodion and chloroform). It is interesting to note here that the cinchona compound was still in use a generation after quinine had been prepared. Tradition is difficult to put down. As Wood and Bache stated in 1843: "We have long been in the habit of using this infusion, and have had reason to be satisfied with its efficacy."⁶ Forty years later the *Dispensatory* still labeled it "an efficient preparation" on which "much reliance was placed."⁶

It is impossible to say whether actual use in prescribing preceded or followed inclusion in the *Pharmacopoeia*, but a working relationship between practitioner and the compendium did seem to exist. Whatever the time relationship, 82 of the 253 items of the primary list of materia medica of the 1850 *Pharmacopoeia*, or just under one-third, and 116 of the 423 preparations given in the *Pharmacopoeia*, or over one-fourth, actually were prescribed by physicians represented in this group of prescriptions. Not a single one of the 91 herbs on the *Pharmacopoeia*'s "Secondary List," it should be noted, was prescribed. These figures cannot be compared precisely with those of the Harvard "Practical Views" mentioned above, but they do seem to indicate a happier situation than the Harvard people envisaged. In sum, it would appear that the practicing physician was reasonably well acquainted with the medications given in the *Pharmacopoeia*.

"... it would appear that the practicing physician was reasonably well acquainted with the medications given in the Pharmacopoeia."

Just how extensive were the armamentaria of these physicians? Gauntt prescribed a total of 110 different items in 200 prescriptions; Parrish 105 different items in 173 prescriptions; and Trimble 70 different items in 120 prescriptions. All three prescribed 32 items in common, including the most important drugs: calomel, camphor, ipecac, opium, morphine acetate, potassium citrate and squill. Gauntt and Parrish both used 23 additional items; Gauntt and Trimble used 11; and Parrish and Trimble used 8.

Altogether these three prescribers called for 179 different items in their 443 prescriptions. These broke down into the following classes of drugs:

Vegetable	105	Mineral	7
Chemical	58	Animal	5
Proprietary			4

Clearly the largest proportion of the prescribed drugs were of vegetable origin. Of them, and of all the drugs, the one most frequently called for was opium. It was called for by the three leading physicians 35 times by itself (as opium, papaver, poppies) and 50 times in combination with ipecac and 15 times in combination with camphor, for a total of 100 times. Among other qualities, opium was prescribed as an anodyne, antispasmodic, suppurific and diaphoretic.

The second most commonly prescribed drug was ipecac. By itself it was prescribed 29 times, with opium 50 times, for a total of 79 times. The value of ipecac in certain dysenteries already was known in 1854, but its use with opium suggests that it was used as a diaphoretic. "No diaphoretic is so powerful," wrote Wood and Bache, "as a combination of opium and ipecachuana, and none is so extensively employed" in rheumatism, bowel affections, and certain pulmonary conditions.⁷

The third most commonly used vegetable drug was camphor. Alone it was prescribed 21 times and with opium another 15 times. Camphor was believed to act on the nervous system and was used for its anodyne and narcotic influence, yet was thought to be moderately stimulating and diaphoretic. The other vegetable drugs that appeared with some frequency were squill (22 times), acacia (29 times), cinchona compound (16 times) and rhubarb (29 times).

Among the chemical remedies the most important was calomel, which was prescribed 54 times by these physicians, in addition to mercury itself which was prescribed 41 times. Calomel, "the Sampson of the materia medica" was obviously in common use despite the strictures that had been raised against it. Both its uses and its dosages, as a recent study has shown, were in dispute.⁸ It was variously thought to be sialogogic, tonic, stimulant, sedative, repulsive and hyposthenic. Even Benjamin Rush had asked for care in its use in children,⁹ yet our three Burlington doctors used it regularly; Parrish prescribed it for his own child, in 12 powders to be taken every two hours, each powder containing two grains of calomel in powdered sugar. The year before (1853), a committee of the New Jersey Medical Society had concluded that "none but the robust can take it [mercury] into their circulation without obvious injury, and even in their cases the safety is questionable."¹⁰ (It would be interesting if we had the prescriptions of 1853 to compare with those we have to see if the report had any noticeable effect.)

Quinine sulphate, written for 20 times, potassium citrate, written for 21 times, both 19th century additions to the materia medica, were the most often prescribed of the new chemicals. Morphine acetate and morphine sulphate, pre-

scribed a total of 23 times, had not yet replaced the older forms of opium.

Perhaps just as significant is the relatively few times that the tartrates were prescribed; altogether cream of tartar, potassium tartrate, tartaric acid and tartar emetic were prescribed but 13 times. Similarly with arsenic, which a recent writer has dubbed "the therapeutic mule."¹¹ It was prescribed but once in the form of arsenite of potassa, Fowler's Solution.

It is a little surprising to note the absence of polypharmacy in these 549 prescriptions. A foreign observer in the United States in 1851 remarked that "most prescriptions are very simple and most consist of powders and pills. In this country one does not use twenty different articles in one medicine, as is still being done in Europe."¹² The Allinson experience bears out the comments of the visitor. Of the prescription forms, 245 were for liquids, 166 for powders, and 107 for pills. The remainder called for a few ointments (20), colloids (5), liniments (5), plasters (4), and miscellanies like a bark, cerate, and seeds. Moreover, 220 of the prescriptions asked for only a single item and 160 asked for only two, that is, over 70 percent of all the prescriptions called for only one or two items. Ninety-four prescriptions required three items, 45 required four, 13 required five, 6 required six and one required seven.

The physician of 1854, in Burlington at least, often prescribed for a day at a time, indeed he not infrequently prescribed a single dose. The final quantities dispensed were generally small. In the liquids, 94 prescriptions called for dispensing one ounce or less, 70 called for from one and a half to two ounces, 51 called for between two and a half and four ounces. Only 19 called for more than four ounces. Similarly, the pills were dispensed in small quantities. Eighty-one prescriptions were dispensed with six or fewer pills, ten prescriptions called for eight to ten pills, 23 from 12 to 16 pills, 18 from 16 to 20 pills, and three from 22 to 30 pills.

This seems to fit in rather well with a practice of daily prescribing for a sick patient, changing the prescriptions each day as the practitioner in his wisdom saw fit. Thus, on January 20, 1854 David Trimble's patient Franklin Newbold was given two ounces of castor oil, ginger and opium. The next day he was given two ounces of potassium citrate in water with the syrup of lemon. The third day he was given 12 grains of opium and ipecac in four powders, and eight grains of the same on the next day. On the fifth day (January 24) he was given the solution of potassium citrate in water with the syrup of lemon to which was added the sweet spirits of nitre. Newbold had a two-day respite on the 25th and 26th (mid-week) but on the 27th he was seen by Dr. Parrish who again prescribed potassium citrate but with four drops of tincture of aconite added. The next day, a Saturday, Dr. Trimble took over again, prescribing 12 grains of ipecac and opium in four powders again. On Sunday five grains of calomel were added to ten of ipecac and opium and dispensed in four powders. On the eleventh day (January 30) Dr. Trimble returned to one ounce of castor oil and ginger with oil of orange flavor. On the 31st Newbold was given one ounce of gentian compound (a tonic, "coroborant" and good for "pure debility of the digestive organs"—a sad commentary on what was being done to Newbold's digestive system) and three pills of kino (an astringent, suppressant of morbid discharges in dysenteries) and opium. Finally, on February 1, he was given eight grains of lead acetate and two grains of opium in four powders and two drams of bicarbonate of soda. Perhaps the bicarbonate of soda did the trick, for

"It is hoped that this study will point up the importance of such things as prescription books, physician's case books, and hospital patient records . . ."

Newbold did not have a prescription filled at Allinson's thereafter, at least to March 25, and the local paper did not include his name in the obituary column.

Newbold was not an extreme example. James Kepack, Dr. Gaunt's patient, was ill at the same time. He was given ten prescriptions between January 28 and February 2 that included castor oil, turpentine, acacia, ipecac and opium, quinine sulphate, rhubarb, a colloidion of cantharides, calomel, bicarbonate of soda, Husband's magnesia, squill, ether, sanguinaria, and wild-cherry bark.

Children received the same treatment, sometimes with doses that appear no smaller than those for adults. Thus, Morgan's child received from Dr. Parrish, from January 24 through February 1, six prescriptions, starting with one ounce of asafoedita tincture, and going to two drams of tincture of veratrum viride, one package of Hodgson's Citric Powder, 12 powders of calomel, ipecac, opium and sugar, one powder of calomel alone, and ending with three powders of ipecac and opium. Lucas' child, a patient of Dr. Gaunt, received rhubarb, cardamon compound, calomel, acacia, bicarbonate of soda, potassium citrate, morphine acetate, tincture of veratrum viride, castor oil, turpentine, carbonate of ammonia, quinine sulphate and citric acid (sometimes with appropriate vehicles and flavors) in seven prescriptions.

CONCLUSION

We do not know what success these physicians had with

these drug therapies. Certainly they appeared to be trying everything that seemed to be called for by the particular symptoms. Sometimes one might sense desperation in the almost trial-and-error therapy, but one must be careful not to judge them by what we know, nor belittle them for using the only drugs known to them.

It is hoped that this study will point up the importance of such things as prescription books, physician's case books, and hospital patient records in determining what the day-by-day practices of medicine and pharmacy actually were. Pharmacopoeias, dispensaries, materia medica texts, learned disputations in journals, and self-serving reports can give a false impression far removed from reality of what the materia medica and drug therapy were really like.

REFERENCES

1. Harrington, TF: *The Harvard Medical School*, vol. 3. New York, Lewis, 1905, p. 1014.
2. The prescription book is now in the possession of the Rutgers University College of Pharmacy.
3. [Robson, C]: *The Biographical Encyclopedia of New Jersey*. Philadelphia, Galaxy, 1877, pp. 39-41.
4. Woodward, EM: *History of Burlington and Mercer Counties, New Jersey*. Philadelphia, Everts & Peck, 1883, pp. 89-91.
5. The information on Trimble was supplied by Archivist Robert Lentz of the Jefferson Medical College and by Christine A. Ruggere, Curator of the Historical Collections, Library of the College of Physicians of Philadelphia.
6. Wood, GB and Bache F: *Dispensatory of the United States*, 5th ed. Philadelphia, Grigg & Elliot, 1843, p. 1010; *Ibid.*, 15th ed., Philadelphia, Lippincott, 1883, p. 793.
7. *Ibid.*, 5th ed., 1843, pp. 422-423.
8. Haller, JS Jr: *American Medicine in Transition*. Champaign, University of Illinois Press, 1981, pp. 79-90.
9. Haller, JS Jr: Medical theory and the use and abuse of calomel in nineteenth century America. *Pharm Hist* 13:70, 1971.
10. Coleman, JB: Report of the effects of mercurial preparations on the living animal tissues. *Trans Med Soc NJ 1800 to 1859* (n.p., n.d.), p. 567.
11. Haller: *American Medicine in Transition*, 90.
12. *Archiv der Pharmazie* (Hannover) 116:226, 1851. (Translation: *Pharm Hist* 23:103, 1981.)

How Contemporary Is Our Nutrition Education? *

KRISTEN W. McNUTT, Ph.D., Chicago

The 1980s offer unprecedented opportunities for communicating to people the benefits of choosing appropriate diets and for helping them act upon this knowledge.

Nutrition education is hardly something newly discovered. There exists in this discipline a rich heritage of expertise and good solid wisdom upon which professionals can build. The "newness" relates to the tools and resources at our fingertips—if they are recognized and capitalized upon.

No pretense is made in this article of putting forth any new insights regarding more effective methods of instruction or innovative messages on current concepts. The objective here is to stimulate thoughts and to reflect together on significant changes that have important implications for those who strive to help others make informed and, *in their own opinions*, appropriate food choices.

This article will address the pertinent changes in nutrition which have occurred over the past twenty years and have had the greatest impact on nutrition education. These changes are divided into three categories: scientific advances, personal life-style variation and societal efforts to enhance nutrition status.

SCIENTIFIC ADVANCES

Within the last twenty years, research has provided new information that has disrupted, to a certain degree, traditional approaches to nutrition education. The diet-heart disease hypothesis, for example, compels educators to include in nutrition messages the risk of high intakes of saturated fat and cholesterol for heart disease in certain people. It is now necessary to be able to deal educationally with incomplete scientific evidence regarding the implications of such research for the population at large.

Other messages from research laboratories are less controversial, but also continue to unfold. The advantages of breast feeding now are accepted widely, but hardly completely understood. The metabolic functions of many trace elements have begun to be elucidated, but nutrition educators are encumbered by limited information regarding human requirements for these nutrients and the lack of food composition data for trace elements. This task is complicated by incomplete information reaching the public and leading them to "self-medication" with supplements. In this respect, nutrition educators have justifiable concerns about possible harm due to nutrient imbalances or toxicities.

Nutrition education messages also must be updated as researchers report that some fat-soluble vitamins function more like hormones than cofactors; that fiber is not one but

many substances, each perhaps with quite different functions; and that past lessons about fat—once regarded as a rather mundane source of energy—now must newer knowledge of essential fatty acids, prostaglandin myelinization as well as atherogenesis. Furthermore, nutritionists must translate for students and for the hypotheses regarding diet and cancer, the safety of ad and countless reported cures and effects—some valid unfounded—of almost every vitamin in the alphabet.

The above are only examples, hardly an inclusive list of scientific advances since the early 1970s. As it states that scientific "truth" may change with the mail. As a profession, has newer information been incorporated into our current nutrition education mes

PERSONAL LIFE-STYLE VARIATION

Life style affects food preferences and nutrient needs. Life styles will continue to change as they have for centuries.

Jogging and exercise are "in" for the 1980s. Such increased expenditures of energy raise questions that nutrition educators must be able to answer. The implications of life style variation go beyond physiology, however. Exercisers are a part of an even larger community of health-conscious, health-conscious persons. This population of nutrition educators to be able to tell them not only how to plan additional balanced energy sources, but also how diet and health and how the "magic" of food can enhance their athletic abilities.

The quest for naturalness pervades our society and nutrition educators must put this need—perceived or real—into nutrition education perspectives. The challenge is to meet by dramatic modifications in the food supply since World War II. Some new products offer improved probiotics supporting health; others are bogus and potentially dangerous.

Economics is another major influence on food choices. Double-digit inflation is squeezing food budgets and complicating the diet planning of persons, especially the elderly with fixed incomes. Unemployment creates an even greater problem because the food budget decreases almost instantly. The challenge to teach balancing dollars and nutrients is much more pervasive today than only a decade ago.

For a variety of reasons, many persons are adopting

*Reprinted with permission of *Contemporary Nutrition*, Vol. 1, No. 1, 1981, a newsletter from the Nutrition Department of General Electric, Minneapolis. Dr. McNutt is Assistant Professor, Department of Public Health, University of Illinois Medical Center, Chicago.

moving toward, vegetarian diets. In the recent past, vegetarian diets often were considered in the context of nutrition misinformation and food faddism.¹ Today, each nutrition educator has a responsibility, regardless of his or her personal food patterns and preferences, to meet a growing public need for planning nutritionally adequate vegetarian diets.

Another major change affecting what people eat is how and where they live. The variability today is great; single-parent households, families where both parents work (perhaps on different shifts), group houses, and singles (students, divorcees, widows/widowers or others) living alone to name a few. Limiting the nutrition education target audience to the housewife-mother is about as relevant as still talking about three sit-down meals a day—all prepared in the family kitchen.

SOCIETAL EFFORTS TO IMPROVE NUTRITIONAL STATUS

Various groups in both the public and private sectors have contributed to improving the nutritional status of the population.

Government influence on diets has grown logarithmically during recent years. Federal food program budgets, even after proposed cuts for the fiscal year 1982, are more than 15 billion dollars. The food stamp, school lunch and women, infants and children (WIC) programs have increased the availability of foods to low-income persons. For public policy reasons based on freedom of choice for the poor, purchases made with food stamp money are not regulated by the federal government. On the other hand, the school lunch and WIC programs do control the foods offered.

The amount of foods affected by the federal government also includes food service in government buildings and food procurement for federal hospitals and prisons. The degree of "control" of food consumed is minimal in these situations, but the potential for influencing the amounts and types of foods available through these channels is significant.

Public sector activities also have impacted on nutrition education. In the early 1970s, the Food and Drug Administration (FDA) introduced the U.S. Recommended Dietary Allowances (U.S. RDA) as the standard for nutrition labeling and the old MDR (Minimum Daily Requirement) became history. Nutrition labeling has not accomplished miracles, but it should be recognized as an information tool—not an educational panacea. This tool would be more useful if more products were labeled. Also needed is development of administratively acceptable and educationally effective methods for presenting to consumers similar information for fresh, nonpackaged foods (e.g., point-of-purchase nutrient composition data). In reality, the effectiveness of the U.S. RDA labeling system currently is limited by the relatively minor accomplishments of nutrition educators to understand and teach this system.

In recent years, both the private and public sectors have heightened their sensitivity to food safety questions. The safety of many substances on the GRAS (generally recognized as safe) list has been reevaluated and, in some cases, reclassified during the 1970s. The Food Safety Council with its joint consumer-industry membership is moving toward developing useful indices of benefit and risk. However, there remains a long way to go in prioritizing hazards and assessing the significance of relative risks—a fundamental process for alleviating unnecessary concern and concurrently eliminating unreasonable risks.

During the last five years, a plethora of reports on dietary

guidance has been released for the public.² These have been issued by government sources as diverse as Congressional staffs, the Surgeon General and interagency coordinating committees. Contributions from the private sector have come from the American Heart Association, the National Nutrition Consortium Board and several professional associations. In the late 1970s, emphasis on "defensive diet planning" characteristic of the Senate Select Committee Dietary Goals replaced guidance for "offensive diet planning," the concepts upon which the Basic Four system was founded. These two approaches merged with the publication in 1980 of the Dietary Guidelines endorsed by the Department of Agriculture and the Department of Health and Human Services.

An analysis of factors affecting contemporary nutrition education would be incomplete without recognizing the roles of the electronic and print media. Nutrition made news in the decade past. Interest in nutrition also was a lucrative business for publishers, networks, advertising agencies, and writers possessing a spectrum of qualifications in this discipline. Currently, the media has heightened consumer awareness of nutrition and, in many instances, soundly buttressed the efforts of nutrition educators. It often has taken the lead in conveying nutrition information to the public.

Despite accomplishments in this arena, education efforts are limited, ironically, by a failure in communications. Few well-trained nutritionists excel as spokespersons on television or radio. Academia rarely prepares nutrition professionals to write for the public or even to collaborate with journalists who have these skills.

The efforts of nutrition educators in the area of public communication via media have been directed primarily toward hair-splitting semantic arguments rather than nutrition education. Comparatively few efforts have been made at linking the scientific knowledge of nutritionists with the creativity of advertisers and the communication skills of writers in order to bring useful nutrition information to people via the most commonly used channels of communication—television, radio, newspapers and magazines.

NUTRITION EDUCATION STRATEGIES

A practical framework for developing a strategy to ensure that nutrition education is kept current is continually to ask: (1) *What* is to be done? (2) *How* is it to be done? (3) *Why* do one thing rather than another? The answer to the first question will contemporize the content of the message based on scientific advances and client needs. Responding to the second question leads to reconsideration of target audiences that might have been overlooked, alternative educational resources not being utilized, and innovations in education and communications that should be utilized.

The third question is the most difficult and the most critical. It requires projecting several steps beyond to anticipate the effect of new activities. Caution must be taken when trying to solve today's problem not to create new problems for tomorrow.

SUMMARY/IMPLICATIONS

Perhaps the greatest potential for nutrition education is tapping the wealth of resources available. The challenge is whether the nutrition profession is willing to delegate part of its role as nutrition educator to media experts, allied health professionals, and other educators and at the same time provide these groups with access to trained nutritionists.

Many people could benefit from this type of collaborative effort. Consumer groups have excellent track records for getting involved in nutrition issues. Grocery stores, from consumer co-ops to national chains, are willing to tackle the problems faced by nutritionists. Voluntary organizations, including health-related associations as well as civic and educational groups, want to get into the act. Health and service delivery personnel from social workers to surgeons realize that nutrition can be a major determinant in the success of their work with clients.

Can educators—will educators—be partner to building

bridges with these human resources? The roles nutrition educators have chosen require continued education, sensitivity to factors that alter what and why specific foods are eaten, and integration of the intellectual and human determinants of appropriate food choices.

REFERENCES

1. The Nutrition Foundation: Nutrition misinformation and food faddism. *Nutrition Reviews* (Supplement) July, 1974.
2. McHutt KW: Dietary advice to the public: 1957-1980, *Nutrition Reviews* 38:353, 1980.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physician Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

This information is compiled by the Schwartz Inter-National Pharmaceutical and Therapeutic Drug Information Center of the Arnold and Marie Schwartz College of Pharmacy and Health Sciences, Long Island University.*

1. Please supply information on Sucralfate

Sucralfate (Carafate®) is a basic aluminum salt of sucrose sulfate being investigated by Marion Laboratories for treatment of peptic ulcer disease. It is expected to be approved for marketing by the FDA during 1981. The drug, which is not absorbed systemically, appears to form a protective barrier at the ulcer site. It blocks gastric acid diffusion and protects the ulcer from acid, pepsin, bile, and other factors in the gastrointestinal tract.^{1,2}

Ishimori *et al.*³ evaluated the effects of sucralfate in 138 gastric and 21 duodenal ulcer patients. Sucralfate was significantly better than placebo in relieving epigastric pain, abdominal distention and in improving ulcer healing.

Marks *et al.*⁴ administered sucralfate or cimetidine to 112 patients with peptic ulcer disease. Sucralfate treatment of duodenal and gastric ulcers compared favorably to cimetidine (sold as Tagamet®) treatment at 6 and 12 weeks.

Martin *et al.*⁵ also found similar results after comparing these two drugs in a controlled trial of 41 patients with duodenal ulcers.

Miyake and co-workers⁶ administered sucralfate or antacid to 167 gastric ulcer patients. The sucralfate group exhibited lower incidence of ulcer recurrence. Mayberry *et al.*⁷ however were unable to demonstrate superiority of sucralfate to placebo in gastric ulcer.

Hollander *et al.*⁸ administered sucralfate or placebo to 215 patients with duodenal ulcers. At two and four weeks, sucralfate-treated patients showed a significantly greater rate of healing than the placebo group.

Moshal and co-workers⁹ administered sucralfate or placebo to 65 patients with duodenal ulcers. These authors noted an increased rate of "large" ulcer healing at six weeks, but were unable to demonstrate a difference when examining small ulcers.

Few adverse effects have been reported with sucralfate therapy. The principal one observed has been constipation.^{3,4}

In conclusion, sucralfate may offer a new and effective means of treating peptic ulcer disease. It appears to produce minimal adverse effects.

REFERENCES

1. Marks IN, Wright JP, Denyer M: New drugs for peptic ulcer. *Br Med J* 281:1281, (Nov) 1980.
2. Anon: *Facts and Comparison*. St. Louis, MI. Facts and Comparisons Inc., 1980, p. 779.
3. Ishimori A: A multi-center, double-blind placebo-controlled study of sucralfate in treatment of peptic ulcer in Japan. Hepatogastroenterology (supplement) abstracts of the XI International Congress of Gastroenterology—A.S.N.E.M.G.E.—Hamburg, (June) 1980.

4. Marks IN, Wright JP, Denyer M, Gasisch JAM, Lucke W: Comparison of sucralfate with cimetidine in the short-term treatment of chronic peptic ulcers. *S A Med J* 57:567, (Apr) 1980.

5. Martin F, Farley A, Gagnon M: Comparative healing capacity of sucralfate and cimetidine in short-term treatment of duodenal ulcer: A double-blind randomized controlled study. Hepatogastroenterology (supplement) abstracts of the XI International Congress of Gastroenterology—A.S.N.E.M.G.E.—Hamburg, (June) 1980.

6. Miyake T, Ariyoshihi J, Suzuki T, Oishi M, Sakai M, Ueda A: Endoscopic evaluation of the effect of sucralfate therapy and other clinical parameters on the recurrence rate of gastric ulcers. *Dig Dis Sci* 25:1, (Jan) 1980.

7. Mayberry JF, Williams RA, Rhodes J, Lawrie BW: A controlled clinical trial of sucralfate in the treatment of gastric ulcer. *Br J Clin Prac* 23:291, 1978.

8. Hollander D: Sucralfate new agent for treatment of duodenal ulcer. Hepatogastroenterology (supplement) abstracts of the XI International Congress of Gastroenterology—A.S.N.E.M.G.E.—Hamburg, (June) 1980.

9. Moshal MG, Spitaels JM, Khan F: Sucralfate in the treatment of duodenal ulcers: A double-blind endoscopically controlled trial. *S A Med J* 57:742, (May) 1980.

2. What information do you have on the new antibiotic, Netilmicin?

Netilmicin, a new semisynthetic derivative of gentamicin administered parenterally, soon may be marketed by Schering. It exhibits a broad spectrum of activity against both gram-positive and gram-negative organisms such as *Staphylococcus aureus*, *Enterobacteriaceae*, *Proteus*, *Serratia* and *Pseudomonas*. Netilmicin may be less ototoxic and nephrotoxic than other aminoglycoside antibiotics currently available.^{1,3}

Chadwick *et al.*⁴ treated 19 patients with urinary tract infections (UTIs) and five patients with systemic infections with netilmicin for four to ten days. Sixteen of the 19 patients with UTIs responded to netilmicin alone, while patients with systemic infections frequently required adjunctive therapy as well. Five of the patients with UTIs developed superinfections.

*The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists: Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Arnold and Marie Schwartz College of Pharmacy and Health Sciences, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 5 p.m.—telephone (212) 622-8989 or 330-2735. Responses to these questions were prepared by J.M. Rosenberg, Ph.D., Pharm. D.; G. Chishti, M. Pharm., M.S.; H. L. Kirschenbaum, M.S., Pharm. D.

Jahre and co-workers² evaluated the use of netilmicin in 33 episodes of pulmonary, urinary tract and soft tissue infections in 30 patients. As determined by clinical and bacteriological means, netilmicin was 85 percent effective in eradicating infections. One case of transient nephrotoxicity and one case of UTI superinfection were noted. The authors concluded that netilmicin is a safe and effective antibiotic.

Favorable results also have been observed when netilmicin was used to treat pelvic inflammatory disease, infections in pediatric patients and severe infections which commonly occur in cancer and burn patients.^{6,9}

The most common adverse effects noted for netilmicin, although possibly less frequent than with other aminoglycosides, were ototoxicity and nephrotoxicity.^{4,9} Patients with renal impairment should have their maintenance dose of netilmicin decreased. Serum levels determinations appear desirable for all patients.

In conclusion, netilmicin may have the potential to produce less ototoxicity and nephrotoxicity than other aminoglycosides.

REFERENCES

1. Owen JA Jr: Two new antibiotics balanced on the scale of similarity. *Hosp Formu* (Nov) 1979.
2. Trestman I, Parsons J, Santoro J, Goodhart G, Kaye D: Pharmacology and efficacy of netilmicin. *Antimicrob Agents Chemother* 13:832-836, (May) 1978.
3. Chadwick P, Bruce AW, Cooke TDV, Hardy GJ: Therapeutic experience with netilmicin. *Can Med Assoc J* 119:926, (Nov) 1978.
4. Plotkin GR: Salient features of the newer antimicrobial agents. *Hosp Formu* (Apr) 1979.
5. Jahre JA, Fu KP, Neu HC: Clinical evaluation of netilmicin therapy in serious infections. *Am J Med* 66:44, (Jan) 1979.
6. Brook I: Tolerance and efficacy of netilmicin in pediatric patients with gram-negative pneumonia. *Chemotherapy* 26:452-460, 1980.
7. Schnider G, Birken RA, Poindexter AN: A comparison of netilmicin and gentamicin in the treatment of pelvic infections. *Obstet Gynecol* 54:5, (Nov) 1979.
8. Munster AM: A new aminoglycoside in the treatment of septic burn patients. *Arch Surg* 114:72-76, (Jan) 1979.
9. Yap BS, Bodney GP: Netilmicin in the treatment of infections in patients with cancer. *Arch Inter Med* 139:640-642, (Nov) 1979.

3. Please provide information on Moxalactam

Moxalactam, a semisynthetic, third generation cephalosporin derivative, is expected to be marketed by Eli Lilly and Company toward the end of 1981. The drug has a long half-life and is administered parenterally. Moxalactam's broad spectrum of activity encompasses beta-lactamase-producing gram-negative bacteria including many strains resistant to aminoglycosides and other cephalosporins. The drug has moderate anti-pseudomonal activity and only moderate activity against *Staphylococci*, *Pneumococci* and other gram-positive bacteria. Its ability to penetrate cerebrospinal fluid (CSF) is markedly better than other cephalosporins.

Gentry *et al.*¹ studied *in vitro* susceptibility of 703 clinically acquired gram-negative organisms to moxalactam. Moxalac-

tam's activity against *Pseudomonas* and *Serratia* (organisms traditionally very difficult to eradicate) exceeded that of several cephalosporins presently commercially available. It was also at least as effective as the aminoglycosides in eradicating these bacteria.

Neu *et al.*² in an *in vitro* study, found that moxalactam demonstrated good activity against *Haemophilus*, *Salmonella* and *Neisseria*.

Schaad *et al.*³ treated 15 neonates and infants with gram-negative meningitis or septicemia with moxalactam. Twelve of these patients previously had failed to respond to therapy with gentamicin, (multisource) or chloramphenicol (multisource). Good cerebrospinal fluid (CSF) concentrations were demonstrated and all patients responded favorably. Other investigators^{4,5} have likewise shown that unlike most other cephalosporin derivatives, moxalactam reaches effective CSF concentrations and thus may be an effective alternative for the treatment of meningitis, especially if due to a gram-negative organism.

Gibbs *et al.*⁶ evaluated the effectiveness of moxalactam in 62 patients with obstetrical/genital infections caused by a variety of gram-negative and gram-positive bacteria. Ninety percent exhibited a good clinical response, defined as the resolution of signs and symptoms of infection within three days without recurrence.

A low incidence of adverse effects has been reported, the most frequent effects involve gastrointestinal and hypersensitivity reactions.⁷

In conclusion, moxalactam may be valuable in treating some gram-negative⁷ bacilli resistant to other antibiotics. Its CSF penetrating ability suggests value in treating coliform and hemophilus meningitis. Unfortunately the drug has only moderate activity against gram-positive bacteria.

REFERENCES

1. Gentry LO, Chappel CL, Ives RT: *In vitro* antibacterial activity of moxalactam (LY127935) against gram-negative bacteria from hospitalized patients. *Curr Ther Res* 28:611-617, (Nov) 1980.
2. Neu HC, Aswapokee N, Fu KP, Aswapokee P: Antibacterial activity of a new 1-Oax-cephalosporin compared with that of other B-lactam compounds. *Antimicrob Agents Chemother* 16:141-149, (Aug) 1979.
3. Schaad UB, McCracken GH Jr, Threlkeld N, Thomas ML: Clinical evaluation of a new broad-spectrum oxa-beta-lactam antibiotic, moxalactam in neonates and infants. *Pediatr* 98:129-136, (Jan) 1981.
4. McKee TK Jr, Wright PF, Gregg CR, Stratton CW: Initial evaluation of kinetics and efficacy of moxalactam (LY-127935) in neonatal systemic gram-negative bacterial disease. *Curr Ther Res* 28:603-610, (Nov) 1980.
5. Kumar A, Aziz MT: Moxalactam in treatment of recurrent escherichia coli meningitis and ventriculitis in an infant with agammaglobulinemia. *Drug Intell and Clin Pharm* 15:50-51, (Jan) 1981.
6. Gibbs RS, Blanco JD, Castaneda YS, St. Clair PJ: Therapy of obstetrical infections with moxalactam. *Antimicrob Agents Chemother* 17:1004-1007, (Jun) 1980.
7. Kammer RS: Moxalactam clinical summary efficacy and safety international symposium on the new generation Beta-lactamase. London, *Antibiotics*. 1981 (abstr.).

Special Committees and Liaison Representatives

Academy of Medicine of New Jersey

- (1) Board of Trustees/Liaison Committee
(Liaison requested by Academy—June 19, 1966)
Alfred A. Alessi, M.D. Hackensack
Robert W. Parvin, M.D. Mount Holly
Myles C. Morrison, Jr., M.D. Morristown
- (2) Postgraduate Medical Education Study Committee
(Representative requested by Academy—November 15, 1964)
Edwin W. Messey, M.D., *Chairman*,
Committee on Medical Education Willingboro
William Pomerantz, M.D., *Vice Chairman*,
Committee on Medical Education Randolph Township

Agent Orange Commission

(Established by Governor—March 1980)

Laura E. Morrow, M.D. Passaic

Aging: Family, Children, and Youth, Auxiliary Committee on

(Liaison requested by MSNJ Auxiliary—November 19, 1972)

Edward L. Blackman, M.D. North Brunswick

American Medical Association Education Research Foundation

(Liaison requested by AMA—October 7, 1951)

Palma E. Formica, M.D., *Chairman, Committee on
Medical Student Loan Fund* New Brunswick

Audit Review Committee (1980-1981 Audit)

(Appointed annually by Board to review previous year's audit)

Howard D. Slobodien, M.D., *Chairman* Perth Amboy
Douglas M. Costabile, M.D. Murray Hill
Anthony P. DeSpirito, M.D. Neptune City
Myles C. Morrison, Jr., M.D. Morristown
Frank Y. Watson, M.D. Montclair

Consultants:
Rudolph C. Gering, M.D., *Treasurer* Pennington
Palma E. Formica, M.D., *Chairman, Committee on
Finance and Budget* New Brunswick
Frank Campo, M.D., *Vice Chairman*,
Committee on Finance and Budget Trenton

Blindness, New Jersey Society for the Prevention of

(Requested by the Society for the Prevention of Blindness—
March 19, 1978)

Malcolm H. Bloch, M.D., *Chairman, Committee
on Conservation of Vision* Morristown

Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Association—
April 25, 1969)

Frank Campo, M.D. Trenton

Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of Committee requested by MSP—
April 16, 1960)

William Greifinger, M.D., *Chairman*,
Board of Trustees Belleville
Armando F. Goracci, M.D., *President* Woodbury
Mr. Vincent A. Maressa, *Executive Director* Lawrenceville
Equal representation from:
Medical-Surgical Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

Cervical Cancer Project Advisory Committee

(Requested by New Jersey State Department of Health—
June 6, 1979)

Gerald F. Hansen, M.D. Hackensack

College of Medicine and Dentistry of New Jersey, Foundation of the

(MSNJ representative appointed yearly by the Board of Trustees to
serve as a trustee, pursuant to the Bylaws of the Foundation)

Arthur Bernstein, M.D. South Orange

Commissioner's Medical Advisory Committee

(Requested by State Commissioner of Health on June 15, 1977,
to assist in the Diagnosis Related Group (DRG) concept)

Alfred A. Alessi, M.D. Hackensack
Augustus L. Baker, Jr., M.D. Dover
Frank Campo, M.D. Trenton
John S. Madara, M.D. Salem
James S. Todd, M.D. Ridgewood
Frank Y. Watson, M.D. Montclair

Consumer Health Education, Advisory Committee of the Office of

(College of Medicine and Dentistry of New Jersey)

Howard D. Slobodien, M.D. Perth Amboy

Crippled Children Commission, State

(Appointed by Governor for 5-year term)

Harry W. Fullerton, Jr., M.D. Carney's Point

Diabetes Coordinating Council

(MSNJ Representation requested by Department of Health—
November 10, 1980)

Arthur Krosnick, M.D. Trenton

Discharge Planning, Task Force Committee on

(Representation requested June 6, 1980)

James J. Lucey, M.D. Perth Amboy

Disputed Claims, Advisory Committee To Review MSP and HSP

(Committee appointed by MSNJ with the concurrence of the New
Jersey Hospital Association, per Board of Trustees—July 16, 1978)

Robert H. Stackpole, M.D., *Chairman* Elizabeth
Donald P. Burt, M.D. Morristown
Frank Campo, M.D. Trenton
John J. Crosby, Jr., M.D. Jersey City
Armando F. Goracci, M.D. Woodbury
Adolph R. Wichman, M.D. Denville
Frank A. Wolf, M.D. Phillipsburg

Education, State Department of

(Liaison requested by the Assistant Commissioner of
Education—September 21, 1958)

Glenn P. Lambert, M.D., *Chairman*,
Special Committee on Child Health Flemington

Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles
—July 29, 1966)

J. Berkeley Gordon, M.D. Rumson

Executive Committee

(Provided in the Bylaws, Chapter III (c))

Armando F. Goracci, M.D., *President*
(*Chairman*) Woodbury
Howard D. Slobodien, M.D.,
President-Elect Perth Amboy
Alexander D. Kovacs, M.D.,
First Vice-President Scotch Plains
Frank Y. Watson, M.D.,
Second Vice-President Montclair
William Greifinger, M.D., *Chairman*,
Board of Trustees Belleville

Augustus L. Baker, Jr., M.D.,
Immediate Past-President Dover
 Arthur Bernstein, M.D., *Secretary (Consultant)* South Orange
 Rudolph C. Gering, M.D., *Treasurer (Consultant)* Pennington

Graduate Medical Education, Advisory Council on
 (Representation requested by CMDNJ)

Edwin W. Messey, M.D., Willingboro

Health Care Administration Board

(Appointed by MSNJ Executive Committee, per Board
 action July 16, 1978)

Daniel J. O'Regan, M.D., Lawrenceville

**Health Maintenance Organization Projects, Advisory
 Committee to Participate in the Review of**
 (Recommended to Executive Director, State Health Planning
 and Coordinating Council, Department of Health)

Henry J. Mineur, M.D., Cranford

**Health Planning and Coordinating Council and/or Its Review
 Committee, State**

(Liaison established January 15, 1978—appointment by
 MSNJ President)

*Howard D. Slobodien, M.D.,

President-Elect Perth Amboy

*Appointed May, 1979. Doctor Slobodien will serve in this capacity
 until he becomes President; at that time, the new Second Vice-
 President will serve as his replacement.

Health Professions Education Advisory Council

(At the request of the Department of Higher Education—to serve
 two years beginning August, 1981)

William J. D'Elia, M.D., Spring Lake
 Francis J. Pizzi, M.D., Trenton (Alternate)

**Heroin and Marijuana, Committee on Investigation of
 Potential Medical Uses for**

(Requested by Department of Health—May, 1981)

Alfonse A. Cinotti, M.D., Glen Ridge
 Lewis L. Coriell, M.D., Camden

Highway Safety Policy Advisory Council, Governor's

(Appointed by Governor—February 3, 1981)

Mr. Vincent A. Maressa Lawrenceville

Hospital Association, New Jersey

(Liaison established at request of New Jersey Hospital
 Association—December 17, 1967)

Frank Y. Watson, M.D., Montclair

Hospital Advisory Council, State Department of Health

(Appointed by the Commissioner of Health for an indefinite term)

Nicholas E. Marchione, M.D., Vineland

**House Maintenance, Staff Policies, and
 Personnel Relations**

(Special Committee created by Board of Trustees—
 September 21, 1958)

Armando F. Goracci, M.D., *President*
(Chairman) Woodbury
 Howard D. Slobodien, M.D., *President-Elect* Perth Amboy
 Alexander D. Kovacs, M.D.,
First Vice-President Scotch Plains
 Frank Y. Watson, M.D.,
Second Vice-President Montclair
 Augustus L. Baker, Jr., M.D.,
Immediate Past-President Dover
 William Greifinger, M.D., *Chairman, Board*
of Trustees Belleville
 Arthur Bernstein, M.D., *Secretary* South Orange
 Rudolph C. Gering, M.D., *Treasurer* Pennington
 Palma E. Formica, M.D., *Chairman,*
Committee on Finance and Budget New Brunswick

Mr. Vincent A. Maressa, *Executive Director* Lawrenceville

Hypertension Study Group

Department of Health

(Appointment pending)

Dental Task Force (formed June 1980)

Micha Oren, M.D., Randolph Township

Pharmacy Task Force (formed June 1980)

Paul Goldfinger, M.D., Dover

**Jalls, Advisory Committee to Review Health Care
 in New Jersey**

(Requested by the New Jersey Public Advocate—March, 1981)

Fred A. Mettler, M.D., *Chairman* Blairstown
 Thomas S. Bellavia, M.D., Hasbrouck Heights
 John F. Marshall, M.D., Trenton
 Edwin W. Messey, M.D., Willingboro
 Rudolf E. Schwaebel, M.D., Mendham

JEMPAC, Conference Committee with

(Established at request of JEMPAC—June 25, 1967)

Daniel J. O'Regan, M.D., *Chairman,*
Council on Legislation Lawrenceville
 Victor H. Boogdianian, M.D., *Chairman,*
Council on Medical Services New Brunswick
 Frank Y. Watson, M.D.,
Second Vice-President Montclair

**Judiciary and Bar, Conference Committee on
 Interrelations with the**

(Established at invitation of Supreme Court—November 17, 1963)

Armando F. Goracci, M.D., *President* Woodbury
 Howard D. Slobodien, M.D.,
President-Elect Perth Amboy
 Alexander D. Kovacs, M.D.,
First Vice-President Scotch Plains
 Frank Y. Watson, M.D.,
Second Vice-President Montclair
 William Greifinger, M.D., *Chairman,*
Board of Trustees Belleville
 Arthur Bernstein, M.D., *Secretary* South Orange
 Rudolph C. Gering, M.D., *Treasurer* Pennington
 Daniel J. O'Regan, M.D., *Chairman,*
Council on Legislation Lawrenceville
 Michael J. Doyle, M.D., *Chairman, Committee on*
Medical Defense and Insurance Neptune
 William J. D'Elia, M.D., Spring Lake
 James E. George, M.D., J.D., Woodbury
 Elmer L. Grimes, M.D., Cherry Hill
 Henry R. Liss, M.D., Chatham
 James S. Todd, M.D., Ridgewood
 Mr. Vincent A. Maressa, *Executive Director* Lawrenceville
 Mr. Joseph C. Lucci, *Director of Medical*
and Insurance Affairs Lawrenceville
 A. Ronald Rouse, Ed.D., *Assistant Director,*
Department of Professional Liability Control Lawrenceville
 Equal representation from:
 Supreme Court Committee on Relations with the
 Medical Profession

Legislation

- (1) Federal Keymen (Mechanism established by MSNJ—April 4, 1954—to serve as official intermediaries between MSNJ and the Federal Legislators)
 15 Congressional District Keymen
 1 Senatorial Keyman
- (2) State Keymen (Mechanism established by MSNJ—July 13, 1952)
 Keymen in 15 Legislative Districts/21 Component Societies
 (List maintained and updated by Council on Legislation and the JEMPAC staff)

Medical Assistance Advisory Council

(At the request of the New Jersey Department of Human
 Services—1980)

William E. Ryan, M.D., Pennington

**Medical Assistants, State of New Jersey, Inc.,
American Association of**
(Liaison requested by Association—September 15, 1963)

Giovanni Lima, M.D. Kearny

Medical Liaison Committees

(High-level conference groups for discussion and
consideration of items of mutual interest)

Armando F. Goracci, M.D., *President* Woodbury
Howard D. Slobodien, M.D., *President-Elect* Perth Amboy
Augustus L. Baker, Jr., M.D. *Immediate*

Fast-President Dover
William Greifinger, M.D., *Chairman*,

Board of Trustees Belleville

Mr. Vincent A. Maressa, *Executive Director* Lawrenceville
(Where number of representatives from other organization is larger
than number of MSNJ representatives, the latter will be increased
from the Presidential Officers to equal the former.)

(1) Medical-Dental
(Liaison requested by the Dental Society—June 10, 1951)

(2) Medical-Hospital
(Liaison established by MSNJ—October 25, 1953)

(3) Medical-Legal
(Liaison established by MSNJ—October 25, 1953)

(4) Medical-Nursing
(Liaison established by MSNJ—April 4, 1954)

(5) Medical-Osteopathic
(Liaison requested by Osteopathic Association—
September 17, 1961)

(6) Medical-Pharmaceutical
(Liaison established by MSNJ—July 26, 1953)

Medicare Peer Review Committee

(Established by the Board of Trustees December 20, 1970, at the
request of the fiscal intermediary. The Committee will review and
evaluate claims involving questions of overutilization under Medi-
care. The composition of the Committee includes six groups of three
members each in the fields of Family Practice, General Surgery,
Orthopedic Surgery, Internal Medicine, Ophthalmology and
Urology.)

Membership Recruitment Committee

(Established by Board on May 19, 1981. Members of Board of
Trustees and AMA Delegation to attend hospital staff quarterly
meetings.)

Augustus L. Baker, Jr., M.D., *Coordinator* Dover

New Jersey Health Sciences Group

(Membership requested by the Group—January 19, 1975)

Edward G. Bourns, M.D. Jamesburg
Paul J. Hirsch, M.D. Bridgewater
Bernard A. Rineberg, M.D. New Brunswick

**New Jersey Health Sciences Group Legislative Affairs
Committee**

(Liaison requested by the Group—November 16, 1975)

Daniel J. O'Regan, M.D., *Chairman*,
Council on Legislation Lawrenceville

**New Jersey State Medical Underwriters, Inc., Board
of Directors**

(1) Appointed to serve as representative for President of MSNJ)
John S. Madara, M.D. Salem

(2) Appointed to serve as representative for President of
NJAOPS

Robert S. Maurer, D.O. Edison

Pharmaceutical Assistance to the Aged Advisory Council

(Appointed by Commissioner of the Department of Human Ser-
vices. Physician representation requested by Division of Medical

Assistance—December 19, 1980)

Frank J. Malta, M.D. Toms River

Pharmacopeial Convention, The United States

(MSNJ invited to appoint a delegate to serve 5-year term—
August 1980)

Frank J. Malta, M.D. Toms River

**Physician-Dentist Loan Redemption Program,
Advisory Committee to New Jersey**

(Appointed by the Chancellor of Higher Education)

Charles S. Krueger, M.D., *Delegate* Mount Holly
Alfred A. Alessi, M.D., *Alternate* Hackensack

Public Health Council, New Jersey

(Nominated at request of Department of Health—October 9, 1980)

Stuart A. Hirsch, M.D. Bridgewater

**Radiation Protection, Advisory
Committee to New Jersey Commission on**

(Consultants in nuclear medicine appointed by Commission)

Henry J. Powsner, M.D. Princeton
Theodore J. Stahl, M.D. New Brunswick
Charles A. Whelan, M.D. Montclair

**Radiation Protection, Consultant Serving New Jersey
Commission on**

(Nomination for appointment to Commission requested—
July 18, 1965)

Frank Gingerelli, M.D. Hackensack

Rehabilitation Services, Division of Vocational

(Liaison requested by MSNJ's Committee on Rehabilitation—
May 1965)

Daniel J. O'Regan, M.D. Lawrenceville

Resolutions, Committee on Annual Meeting

(Established by Board of Trustees—July 18, 1971, to review all
resolutions in advance of the Annual Meeting)

Charles S. Krueger, M.D., *Chairman* Mount Holly
Alfred A. Alessi, M.D. Hackensack
Augustus L. Baker, Jr., M.D. Dover

Safety Council, New Jersey State
(Provided in Council Bylaws)

Armando F. Goracci, M.D., *President* Woodbury
Maurice E. Goldman, M.D., *Chairman, Special Committee on
Occupational Health, Workmen's Compensation and Rehabilitation
(President's Representative)* Linden

State Board of Medical Examiners

(Per Board action—December 15, 1974)

Trustees designated to attend monthly meetings on a rotating basis
(Per Board action—August 8, 1979)

Howard D. Slobodien, M.D., *President-Elect* Perth Amboy
Mr. Martin E. Johnson, *MSNJ Staff Member* Lawrenceville

Student Association, Medical Society of New Jersey

(Formed July 17, 1977)

(Per Board action—October 21, 1979)

Palma E. Formica, M.D. (*Member of Board
of Trustees*) New Brunswick
Mr. Charles Spingola (*Student*) Newark

**Widows and Orphans of Medical Men of New Jersey,
Society for Relief of**

(Liaison requested by Society—May 17, 1959)

Joseph R. Jehl, M.D. Clifton

DOCTORS' NOTEBOOK

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

(I have asked Karen Filkins, M.D., assistant professor of obstetrics and gynecology and director of the ob/gyn genetics division at CMDNJ-New Jersey Medical School, to serve as guest columnist this month. Dr. Filkins, a graduate of this school, provides an update on prenatal diagnostic testing, which is her specialty.)

Recent advances in obstetrical technology that permit an accurate assessment of the well-being of the fetus, coupled with information for both parents and physicians on the subject of genetic ailments, has resulted in a thriving genetics division at CMDNJ-New Jersey Medical School's Department of Obstetrics and Gynecology.

Approximately 1,000 genetic amniocenteses and an almost equal number of diagnostic ultrasound scans are performed annually at CMDNJ-College Hospital, which is located on the Newark campus. We have one of the highest case loads in the nation.

(For those not in this field, amniocentesis is the drawing of fluid from the amniotic sac for testing purposes and ultrasonography provides a soundwave picture of the fetal and placenta location.)

The most frequent reason women are referred for fetal diagnosis is age; those over 35-years old are receiving special attention, almost automatically. But there are other indications for these sophisticated tests and they include: advanced paternal age, a previous child with a chromosomal abnormality, if either parent is a known carrier of a balanced or unbalanced chromosomal abnormality, a previous child with a neural tube defect or family history of such a defect, if the mother is a known or suspected carrier of a serious x-linked

recessive disorder, if both parents are carriers of a diagnosable autosomal recessive disorder or if there is a history of habitual spontaneous abortion.

Prior to any prenatal genetic diagnostic procedure, genetic counseling is carried out in order to identify clearly areas of risk. Often risk areas constitute the reasons for the initial referral and when feasible, additional diagnostic tests are offered to the couple.

Routine tests on the amniotic fluid include chromosomal analysis of fetal cells following growth in tissue culture and biochemical analysis of the fluid for feto protein, a substance found when there is an open neural tube defect such as spina bifida. Additional testing for detectable inborn errors of metabolism, such as Tay-Sachs disease or sickle cell anemia, are performed only where indicated.

Ultrasound examination done prior to amniocentesis routinely includes determination of fetal viability, estimation of fetal age, observation of the gross appearance of fetal head, spine, limbs, placental localization, occurrence of uterine anatomic variations of abnormalities such as myomas, occurrence of multiple gestation and determination of the ideal site for amniocentesis and approximate depth of penetration needed for amniotic fluid aspiration.

The routine tests described above are widely used clinically. However, many of the additional tests, although still somewhat experimental, rapidly are gaining acceptance and are destined to become standard practice.

Still in the realm of clinical research is ultrasound diagnosis of fetal congenital malformations. Certain limb defects may be detectable. Here at CMDNJ-College Hospital, ultrasonography successfully has detected fetal neural tube defects including hydrocephaly,

gastrointestinal defects, renal defects and cardiac defects. The use of ultrasonography to detect fetal and placental anomalies is not restricted to the second trimester of pregnancy since certain defects, or even suspicious signs of potential defects, may not be apparent until the third trimester.

Excessive amniotic fluid (hydramnios) may be associated with neural tube defects, gastrointestinal, hepatic, cardiac or other defects, whereas insufficient amniotic fluid (oligohydramnios) may be associated with renal or other defects. Such variations in amniotic fluid volume may be reflected by size-to-date discrepancies during a pregnancy. On the other hand, the condition may not be noted by the obstetrician until later in the pregnancy.

Prenatal ultrasound diagnosis in cases where there may be fetal or placental pathology can lead to appropriate early intervention. When a correctable defect is found, we can arrange for immediate pediatric surgical intervention following birth.

An example of such a case in our unit is that of a woman whose fetus was found to have duodenal atresia (blockage) on ultrasound examination. For obstetrical reasons, the woman was scheduled for a cesarean section and consented to surgery on her newborn even prior to the section. Therefore, no time was lost in performing the necessary, lifesaving operation on her baby.

There are many uses for ultrasonography in obstetrics and gynecology other than those highlighted above. When history, palpation and biochemical tests are insufficient to make a diagnosis, we increasingly should be able to turn to this method of inspecting the internal structures. Its use is important in many fields of medicine and its value will grow in years to come.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY/IMMUNOLOGY—Leonard Cohen, M.D., 7545 York Drive, Clayton, MO 63105. New York University 1977. Also general internal medicine. Board certified (IM). Board eligible. Multi-specialty group, partnership, solo, academic. Available July 1982.

CARDIOLOGY—Raj D. Savajiyani, M.D., 3807 North 30th Street, Apt. 25, Phoenix, AZ 85016. Baroda (India) 1975. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1982.

Anil Rastogi, M.D., 1350 West Bethune, Apt. 1502, Detroit, MI 48202. Rajasthan (India) 1974. Also, general internal medicine. Board certified (IM). Cardiac catheterization—group, partnership, solo. Available July 1982.

Mark Leenthal, M.D., 1164-4 Bibbs Road, Voorhees, NJ 08043. SUNY-Stonybrook 1977. Board eligible. Group or partnership—cardiology or cardiology/internal medicine. Available July 1982.

EMERGENCY ROOM—Pramila M. Umaphathi, M.D., P.O. Box 1108, 27 Eagle Avenue, Apt. B, North Park, Wheeling, WV 26003. Madras (India) 1971. Also, family practice and obstetrics/gynecology. Group practice or hospital emergency room. Available.

FAMILY MEDICINE—Allan P. Olivieri, M.D., 120 West 80th Street, New York, NY 10024. Cornell 1976. Board certified. Group, partnership, hospital affiliate (full time). Available.

Louis Verardo, M.D., 21 Walnut Road, Apt. 1—2A, Glen Cove, NY 11542. University of Bologna (Italy) 1978. Board eligible. Group (private or hospital-sponsored), preferably with opportunities for medical school/residency affiliation (for teaching purposes). Available.

K.J. Smith, M.D., P.O. Box 486, Durham, PA 18039. University of Washington 1976. Board eligible. Group. Available.

Catherine M. Sharkness, M.D., 6 Dartmouth Avenue, Apt. 2-A, Bridgewater, NJ 08807. Medical College of PA 1979. Board eligible. Group, partnership. Available August 1982.

Lisa Nierenberg, M.D., Somerset Family Practice, Rehil Avenue, Somerville, NJ 08876. Penn State 1979. Board eligible. Group (small). Available August 1982.

Pramila M. Umaphathi, M.D., P.O. Box 1108, 27 Eagle Avenue, Apt. B, North Park, Wheeling, WV 26003. Madras (India) 1971. Also, emergency room and obstetrics/gynecology. Group practice or hospital emergency room. Available.

GASTROENTEROLOGY—Yong Wun Chung, M.D., 3937 Lankenau Avenue, Philadelphia, PA 19131. Chonnam (Korea) 1972. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1982.

INTERNAL MEDICINE—Kamal M. Bakri, M.D., 88 Slate Creek Drive, Apt. #3, Cheektowaga, NY 14227. Baroda (India) 1973. Subspecialty, oncology. Board certified. Group, solo, or partnership. Available.

Peter E. Schottlander, M.D., 2408 Whittier Street, Rahway, NJ 07065. CMDNJ 1979. Board eligible. Partnership or group. Available July 1982.

Ruth C. Wang-Liang, M.D., 68 Colfax Road, Wayne, NJ 07470. Temple 1978. Board eligible. Group, HMO. Available.

Anthony A. Losardo, M.D., 1545 East 5th Street, Brooklyn, NY 11230. Einstein 1977. Subspecialty, cardiology. Board certified. Group or partnership. Available July 1982.

Alan Greenwald, M.D., 51-D Wedgewood Drive, Stratford, CT 06497. Chicago Medical 1976. Subspecialty, gastroenterology. Board certified. Board eligible (gastroenterology). Group, partnership, or multi-specialty group. Available July 1982.

Chaitanya S. Kadakia, M.D., Covered Bridge Terrace, Apt. D-2, Philippi, WV 26416. M.S. University (India) 1976. Board certified. Solo, associate, group. Available July 1982.

Neil H. Caplan, M.D., 27 West Penn Street, Long Beach, NY 11561. Bowman-Gray 1965. Board eligible. Outpatient (health service, clinic or other)—preferably in northern NJ. Available.

Herbert F. Rest, M.D., 2 Belmont Avenue, Brattleboro, VT 03501. Hahnemann 1965. Group. Available December 1981.

Jay I. Lipoff, M.D., 214 East Spooner Road, Milwaukee, WI 53217. NYU. Subspecialty, cardiology. Board certified. Group or solo. Available January 1982.

Bakhti J. Sinor, M.D., VA Medical Center, Dept. of Medicine, Northport, NY 11768. Seth G.S. (India) 1973. Subspecialty, hematology/oncology. Board certified (hematology). Group, partnership in oncology/hematology. Available.

Jonathan R. Anolik, M.D., 6107 Breezewood Court, #203, Greenbelt, MD 20770. Loyola/Stitch 1977. Subspecialty, endocrinology. Board certified. Group or partnership. Available July 1982.

Jerome S. Fischer, M.D., 1400 South Joyce Street, Arlington, Va 22202. Jefferson 1977. Subspecialty, endocrinology. Board certified. Group or partnership. Available July 1982.

T.M. Gupta, M.D., 8093-202 Valcour Avenue, St. Louis, MO 63123. Osmania (India). Subspecialty, cardiology. Board eligible. Solo, group, partnership (trained in all aspects of invasive/non-invasive cardiology). Available July 1982.

Harold S. Wilkes, M.D., 350 East 17th Street, Apt. 9-D, New York, NY 10003. New York Medical 1977. Subspecialty, cardiology. Board certified. Group, partnership. Available July 1982.

NUCLEAR MEDICINE—Maria I. Straub,

M.D., 254 Frances Street, Teaneck, NJ 07666. University of Budapest (Hungary) 1967. Special interest, diagnostic radiology. Board eligible. Available.

OBSTETRICS/GYNECOLOGY—Mohammed M. Mohiuddin, M.D., 215 Locksley Road, Syracuse, NY 13224. Osmania (India) 1973. Board eligible. Any type practice except academic position. Available.

Mridu B. Agarwal, M.D., 318 East 15th Street, Apt. 6-A, New York, NY 10003. Lady Hardinge (India) 1971. Solo, group, or partnership. Available.

Jung Fu Chen, M.D., P.O. Box 218, Petersburg, WV 26847. National Taiwan University 1956. Board eligible. Partnership, solo. Available.

Tsu Ming Chu, M.D., 269-19 80th Avenue, New Hyde Park, NY 11040. Kaoshing Medical (Taiwan) 1972. Board eligible. Partnership, group, fellowship, full-time institute. Available.

Myles E. Dotto, M.D., 44 Lyndhurst Avenue, Providence, RI 02908. CMDNJ 1975. Board eligible. Group, partnership, solo. Available July 1982.

Gary K. Schneider, M.D., 145 East 27th Street, Apt. 5-B, New York, NY 10016. SUNY-Downtown 1978. Board eligible. Group, partnership, or academic. Available July 1982.

Pramila M. Umaphathi, M.D., P.O. Box 1108, 27 Eagle Avenue, Apt. B, North Park, Wheeling, WV 26003. Madras (India) 1971. Also, emergency room or family practice. Group or hospital emergency room. Available.

OPHTHALMOLOGY—Charles D. Howard, MD., 2605 Stearns Hill Road, Waltham, MA 02154. Guadalajara (Mexico) 1976. Special interest, corneal or external diseases. Solo, partnership, single-specialty group. Available July 1982.

ORTHOPEDICS—Cary Ian Skolnick, M.D., 2250 North Circle Drive, Ann Arbor, MI 48103. Creighton 1977. Partnership, group. Available July 1982.

OTOLARYNGOLOGY—Donald V. Wilson, M.D., 20 Lahiki Circle, Aiea, Hawaii 96701. Temple 1975. Board certified. Group, partnership, will consider solo. Available August 1982.

PATHOLOGY—Alexander J. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified (AP and CP). Any type practice including institutional. Available.

Anna Kumar, M.D., 6223-B Newport Avenue, Norfolk, VA 23505. J.L.N. Medical (India) 1972. Board eligible (AP/CP). Group, solo, or partnership. Available.

Daniel Williams, Jr., M.D., 77 Rippowam Road, Apt. A, Stamford, CT 06902. Vanderbilt 1975. Special interest—clinical pathology and blood banking. Board certified. Any type practice. Available.

PEDIATRICS—Fe C. Aplasca, M.D., 41-56 77th Street, Elmhurst, NY 11373. Philippines 1973. Board certified. Any type practice. Available.

Yogesh J. Pandya, M.D., 24 Paerdegat—

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule contains:

Pentylentetrazole 100 mg.
Nicotinic Acid 100 mg.
Ascorbic Acid 100 mg.
Thiamine HCL 25 mg.
L-Glutamic Acid 50 mg.
Niacinamide 5 mg.
Riboflavin 2 mg.
Pyridoxine HCL 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



15th Street, Brooklyn, NY 11236. Baroda (India) 1973. Board eligible. Solo, group, partnership, hospital-based. Available.

Susheela Raghunathan, M.D., 9 Weston Place, East Brunswick, NJ 08816. India 1973. Board eligible. Group, institutional, clinic, emergency room, or house staff, student health center. Available.

Bernard Samtoy, M.D., 4040 Marshall Avenue, Lorain, OH 44053. Montpellier (France) 1974. Subspecialty, pediatric nephrology. Board certified. Group or partnership. Available.

Richard Dicker, M.D., 23 Park Avenue, Caldwell, NJ 07006. Guadalajara (Mexico) 1978. Group or partnership. Available July 1982.

PHYSIATRY—Lisa Bhansali, M.D., 49 Hamilton Lane South, Plainsboro, NJ 08536. LTM Medical College (India) 1972. Board eligible. Group, clinic, or as staff. Available.

PSYCHIATRY—Paul L. Maitheny, M.D., 99 Pawnee Road, Lakewood, NJ 08701. University of Graz (Austria) 1951. Board eligible. Available.

PULMONARY DISEASES—Paul M. Friedman, M.D., 1303 York Avenue, New York, NY 10021. SUNY-Downstate 1977. Board certified (IM). Group or partnership. Available July 1982.

Surinder K. Aneja, M.D., 90A Garden Village Drive, Apt #4, Cheektowaga, NY 14227. Punjab (India) 1974. Also, general internal medicine. Board certified (IM). Group or solo. Available July 1982.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379. Shah (India) 1969. General practice and rehabilitation medicine. Available on three months' notice.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available.

Thomas A. Giangrosso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available.

SURGERY, GENERAL—S.R. Bajina, M.D., E1501, Park Towne Place, 2200 Benjamin Franklin Parkway, Philadelphia, PA 19130. Special interest—gastrointestinal endoscopy. Board certified. Solo, group, institutional-based. Available.

Rajendra M. Agarwal, M.D., 318 East 15th Street, New York, NY 10003. King George's (India) 1968. Solo, group, or partnership. Available.

P. Joshua Mammen, M.D., 404 West 51st Street, Apt. 2-B, New York, NY 10019. Trivandrum (India) 1970. Board eligible. Group, partnership, solo. Available.

B. Paulauskas, M.D., Route 1, Box 273-M, Lake Placid, FL 33852. Lithuania 1972. Special interest, vascular surgery. Board eligible. Group, partnership, solo. Available.

Kong Hua L. Go, M.D., 605 Louisiana Avenue, Apt. 17-A, Brooklyn, NY 11239. Far Eastern (Philippines) 1973. Board eligible. Any type practice. Available.

Job S. Kakkaseril, M.D., 3194 McGill Lane, Cincinnati, OH 45239. Pradesh (India) 1972. Board eligible. Group, solo, or partnership. Available.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available.

Inder J. Singh, M.D., WCMC #1C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available.

UROLOGY—Talluri Balaji, M.D., 1926 West Harrison St., Apt. 916, Chicago, IL 60612. Osmania (India) 1973. Solo. Available July 1982.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available.

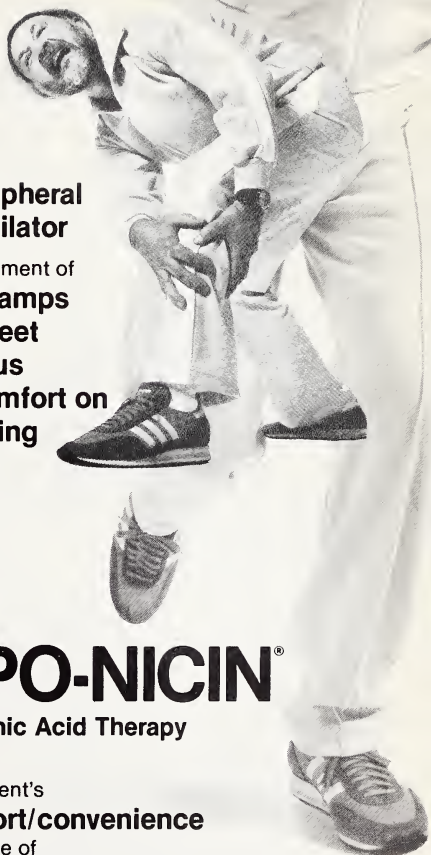
Mahendra S. Shah, M.D., 62 Forsythia Lane, Paramus, NJ 07652. Baroda (India) 1968. Board certified. Group or partnership. Available.

Tahmoures Furoozi, M.D., 3646 Tuscula Avenue, Seaford, NY 11783. Esfahan University (Iran) 1966. Board eligible. Any type practice. Available.

Albert E. Kaufman, M.D., 2020 Forestdale Drive, Silver Spring, MD 20903. Ghent (Belgium) 1974. Board certified. Group, partnership. Available.

A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on
standing



LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:

Nicotinic Acid	.....300 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	.....250 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	.....100 mg.
Niacinamide	.....75 mg.
Ascorbic Acid	.....150 mg.
Thiamine HCL (B-1)	.....25 mg.
Riboflavin (B-2)	.....2 mg.
Pyridoxine HCL (B-6)	.....10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



216th Annual Meeting

May 14-17, 1982

Resorts International, Atlantic City

Proposed Daily Schedule

Friday, May 14, 1982

- 3:30 p.m.—Board of Trustees' Meeting
- 5:00 p.m.—Delegate Registration

Saturday, May 15, 1982

- 7:30 a.m.—Delegate Registration
- 9:00 a.m.—House of Delegates
- 9:00 a.m.—Message Center, Coffee Lounge, Exhibits, Auxiliary Arts and Hobbies Open
- 10:30 a.m.—House of Delegates (election)
- 12:00 noon—Golden Merit Award Ceremony followed by Reception for Award Recipients
- 1:00 p.m.—Reference Committee Meetings: "A", "B", "C", "D", "E", "F", "G", "H", Constitution and Bylaws
- 6:00 p.m.—JEMPAC Wine and Cheese Reception

Sunday, May 16, 1982

- 7:00 a.m.—JEMPAC Breakfast
- 8:00 a.m.—Registration Opens

- 9:00 a.m.—Message Center, Coffee Lounge, Exhibits, Auxiliary Arts and Hobbies Open

- 9:00 a.m.—Scientific Sessions
- 1:00 p.m.—Scientific Sessions
- 4:00 p.m.—Annual Meeting—Board of Governors of MIE
- 6:30 p.m.—Inaugural Reception
- 8:00 p.m.—Inaugural Dinner

Monday, May 17, 1982

- 8:00 a.m.—Registration Opens
- 9:00 a.m.—Message Center, Coffee Lounge, Exhibits, Auxiliary Arts and Hobbies Open
- 9:00 a.m.—House of Delegates (to consider reference committee reports)
- 12:00 noon—Message Center, Coffee Lounge, Exhibits, Auxiliary Arts and Hobbies Close
- 12:00 p.m.—House of Delegates adjourns for lunch
- 1:30 p.m.—House of Delegates reconvenes
- 4:00 p.m.—House of Delegates adjourns
- 7:00 p.m.—Board of Trustees' Dinner-Meeting

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physician Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

The Doctor Glut

August 5, 1981

To The Editor:

I would like to take issue with the commentary of Dr. Donald Louria ("Coping with the Impending Doctor Glut," *J Med Soc NJ*, 78:503-504, 1981). It is a basic fact of life that one does not build upon a weak foundation lest his dreams fall apart. Dr. Louria begins his dissertation with numbers galore, citing some studies that have not been well received by our own medical community. The GMENAC report has been criticized sharply from many sources and is not the most noteworthy source with which to begin a thesis.

Secondly, quoting from one's own literature does not present a fact but only serves to emphasize what already has been said. Repetition never substitutes for hard data. I believe that there are several investigators who are not so certain that there will be the physician glut averred by Dr. Louria.

Dr. Louria directs his attention to the American foreign medical graduate "problem." This smacks a little of the "problem" dealt with in Germany in the thirties and forties and the "problem" presenting itself among Palestinians in the middle East today. One must be super careful before he singles out a group as being a "problem" to be dealt with.

Basic freedoms granted to all of us under our Constitution must be cherished by all, including those who find our numbers objectionable. Whether there will be a surfeit of physicians in the near future or not does not, in any way, permit denial of the right of the freedom to choose. The American studying abroad has the constitutional privilege of choice—that of career, as well as location in which this career is exercised.

The possibility of increasing the severity of the entrance and licensure examinations does not appeal to Dr. Louria as a viable alternative. I do believe that Dr. Louria does not understand that this alternative may be the only means available to him. An issue that soon will come into sharp focus is

that of the proprietary off-shore Caribbean schools which crank out students by the hundreds with little recognition within our own country as to standards of education. Perhaps investigation of the manner in which they receive recognition and acceptance in our country will serve as a more practical and constitutional first step toward relieving a potential surfeit.

I take no issue with the concept that Americans studying medicine abroad must be scrutinized as to the quality of that education so that they meet reasonable standards in our communities. I cannot accept, in any manner, the concept that an across-the-board restriction to the entrance into our country is moral, ethical, legal or even desired by more than a small majority of academicians.

(signed) Barry A. Cohen, M.D.
Chairman-Elect, Autonomous
University of Guadalajara

T-Tube Removal

August 14, 1981

Dear Sir:

I read with great interest the article "Bile Peritonitis After Routine T-tube Removal" by Rosenberg, Konigsberg and Finkelstein (*J Med Soc NJ* 78:532-533, 1981) in which they reported two patients who developed bile peritonitis requiring reoperation. They indicated that this complication developed as a result of improper preparation of the T-tube and, secondly, removing the T-tube on the tenth postoperative day.

In my 40 years experience I have not encountered this complication even though I have not used the "trimmed T-tube" because while it is an additional precaution to trim the circumference of the horizontal limb of the T-tube, I have not found it necessary. I believe the main factor is one of hydrodynamics. I perform postoperative cholangiogram on the seventh postoperative day and allow the tube to drain one additional day before clamping it completely without gradient clamping. Leaving the clamped tube in place for an additional five to seven days allows the T-tube tract to become formed and the hydrodynamic

flow of bile through the common duct to develop so that removal of the T-tube at the 14th day results in little if any bile drainage from the tract. Usually any residual drainage from the abdominal wall tract will cease in 24 hours.

I am calling attention to this principle because it applies to enterostomy tubes and cecostomy tubes as well as T-tubes. Any tube clamped into disuse for five to seven days prior to removal will not result in cutaneous fistulas when removed.

(signed) Lester A. Barnett, M.D.
Clinical Professor of Surgery
Hahnemann Medical College

Malpractice Insurance for the Semiretired Physician

August 15, 1981

Sirs:

I am a physician, a member of the Medical Society of New Jersey, who closed his office for the practice of dermatology two years ago. I continue professional work in two hospital clinics on a parttime basis.

I am a member of the Medical Inter-Insurance Exchange and changed my malpractice insurance status very recently under the "retired physician" status. The rules and bylaws of the Medical Inter-Insurance Exchange state that if you do not hold regular office hours or do not treat any new patients—except at clinics—you may be covered by the retired physician policy, the annual premium for which is only a fraction of the previously paid premium. Anyone meeting such qualifications for the retired physician category will be provided with coverage for incidents occurring on or after the effective date and prior to the expiration of his individual policy. Claims arising from treatment rendered during the time the policy is in effect with the Exchange are honored regardless of when these claims are presented.

I understand that some 200 New Jersey physicians find themselves in a situation similar to mine, and I believe that not all are fully informed of the mentioned possibility.

(signed) Paul L. Grosner, M.D.

Symposium

October 30-31, 1981
The Plaza Hotel
New York, N.Y.

Grand Rounds In Medicine: RECOGNITION AND MANAGEMENT OF THROMBOEMBOLIC DISORDERS

Symposium Objectives

The objective of this symposium is to provide clinically relevant information to aid the practicing physician in the recognition of patients with thromboembolic disorders and proper patient selection for the use of anticoagulant or antiplatelet therapy. Panel discussions will focus on actual case histories representative of management problems confronting the physician in private practice.

Symposium Co-Chairmen

Richard Gorlin, MD

Murray M. Rosenberg Professor
Chairman, Department of Medicine
Mount Sinai School of Medicine
Physician-in-Chief
The Mount Sinai Hospital
New York, New York

Louis M. Aledort, MD

Professor of Medicine
Vice Chairman, Department of Medicine
Mount Sinai School of Medicine
New York, New York

Symposium Accreditation:

As an organization accredited for continuing medical education, The Page and William Black Post-Graduate School of Medicine of the Mount Sinai School of Medicine (CUNY) certifies that this continuing medical education offering meets the criteria for ten (10) credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed.

Registration

For additional information and registration, call Ms. Jayne Gross at 800-223-8978/9 outside of New York State or 212-752-4530 in New York State.



CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

CARDIOLOGY

Nov.

- 4 **Mitral Valve Prolapse**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 4 **Cardiac Rehabilitation**
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 10 **Cardiac Rehabilitation**
8-9:30 p.m.—Shore Memorial Hospital, Somers Point
(*Shore Memorial Hospital and AMNJ*)
- 16 **Cyanotic Congenital Heart Disease in Neonates**
12 noon-1 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)
- 18 **Type A Behavior in Coronary Heart Disease and Hypertension**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)

Dec.

- 2 **Cardiology Conference**
3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(*Rutgers Medical School, Somerset County Heart Association and AMNJ*)
- 4 **Cardiomyopathy**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 10 **Cardiac Arrhythmias**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Nov.

- 3 **Leukemia Update**
- 10 **Prostaglandins in Pain and Arthritis**
- 17 **Anaerobic Infections**
8-9 a.m.—Greater Paterson General Hospital, Wayne
(*Greater Paterson General Hospital and AMNJ*)
- 4 **Alzheimer's Disease-Preserving Life Functions**
9:30 a.m.-4 p.m.—1155 Pleasant Valley

Way, West Orange
(*Daughters of Israel Pleasant Valley Home, Montclair State College and AMNJ*)

- 4 **Screening Measures in Adult and Pediatric Medicine**
1:30-2:30 p.m.—Rutgers Community Health Plan, New Brunswick
(*Rutgers Community Health Plan and AMNJ*)
- 4 **New Treatments in Arthritis**
8:30 a.m.-3 p.m.—Rutgers Medical School, Piscataway
(*Arthritis Foundation, NJ Chapter, NJ Rheumatism Association and AMNJ*)
- 4 **Drug Addiction**
11:30 a.m.—Columbus Hospital, Newark
(*AMNJ*)
- 4 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(*AMNJ*)
- 4 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section of AMNJ*)
- 4 **Captopril and Beta Blockers in Treatment of Hypertension**
- 11 **Calcium Antagonists**
3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(*Rutgers Medical School, Somerset County Heart Association and AMNJ*)
- 4 **Mitral Valve Prolapse**
- 18 **Assessment of Thyroid Function**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 4 **Problems of Malnutrition and Obesity**
- 11 **Nutrition and Resistance to Infection**
- 18 **Type A Behavior in Coronary Heart Disease and Hypertension**
- 25 **Antibiotic Prophylaxis**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 4 **Endocrine Conference**
- 11 **3:30-5 p.m.—Rotates between Newark**
- 18 **Beth Israel Medical Center, College**
- 25 **Hospital, Newark and VA Medical Center, East Orange**
(*Endocrinology Section of AMNJ*)
- 5 **Sports Medicine/Trauma**
9 a.m.—Freehold Area Hospital
(*AMNJ*)
- 5 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(*Endocrinology Section of AMNJ*)
- 6 **Medical Grand Rounds**
11:30 a.m.—College Hospital, Newark
(*Endocrinology Section of AMNJ*)
- 6 **Workup of the Jaundiced Patient**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 6 **Gastrointestinal Bleeding**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 6 **Brain Trauma Management: A Quest for Solutions**
9 a.m.—The Meadowlands Hilton, Secaucus
(*NJ Rehabilitation Hospital and AMNJ*)
- 10 **Diabetes**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 11 **Hepatitis, Current Diagnosis and Management in a Long-Term Care Facility**
2 p.m.—John E. Runnells Hospital, Berkeley Heights
(*AMNJ*)
- 11 **Holistic Medicine**
9:30-11:30 a.m.—Dover General Hospital
(*Dover General Hospital and AMNJ*)
- 12 **Gerontology Meeting**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)
- 13 **Hypertension**
8:30-9:30 a.m.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)
- 16 **Myasthenia Gravis**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 16 **Cyanotic Congenital Heart Disease in Neonate**
- 30 **Varicella**
12 noon-1 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)
- 17 **Drug-Induced Liver Disease**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 18 **Malignant Conditions of the Blood-Forming Organs**
9 a.m.-4 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)
- 18 **Transient Ischemic Attack**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(*Columbus Hospital and AMNJ*)
- 18 **Chemotherapy Update**
1-3 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 18 **Oat Cell Carcinoma—Lung**
1-2:30 p.m.—VA Medical Center, Lyons
(*VA Medical Center and AMNJ*)
- 20 **Infectious Disease/Bacterial Endocarditis**
11 a.m.—Freehold Area Hospital
(*AMNJ*)
- 24 **Endocrinology and Metabolism**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)



INTERNAL MEDICINE BOARD REVIEW

Wednesdays, 4:00 to 7:00 p.m.

January 6 to June 23, 1982
(No Session April 7th)

COURSE DIRECTORS:

Saul J. Farber, M.D.

Frederick H. King, *Professor of Internal Medicine and Chairman,
Department of Medicine*

Louis Shenkman, M.D.
Associate Professor of Medicine

Mitchell H. Charap, M.D.
Instructor in Medicine

COURSE DESCRIPTION

An improved method by which to prepare for either board certification or recertification in medicine. In an attempt to provide more effective retention of cognitive material, the Post-Graduate Medical School has spread the basic and clinical information over a six-month time span with weekly three-hour sessions running from January through June 1982.

Each teaching session is divided into two parts: 1) a brief summary lecture emphasizing the essential and relevant status of the area under discussion and 2) a self-assessment examination workshop based on questions found on certification and recertification examinations providing responses with explanations of appropriate and inappropriate answers. A principle goal of the course is to provide the *reasoning* behind the identification of responses to questions. At each session written material pertinent to the following week's subject will be distributed to the registrants.

PROGRAM TOPICS

Cardiology	Diabetes	Gastroenterology	Endocrinology
Hematology	Hypertension	Neurology	Clinical Immunology
Infectious Diseases	Neoplastic Diseases	Pulmonary Diseases	Nephrology
Skeletal Diseases	Dermatology		

FACULTY

Francis V. Adams	Ephraim Glassman	Itzhak Kronzon	David M. Rapoport
Steven B. Abramson	Roberta M. Goldring	Mark H. Levin	Stephen B. Richardson
Bertrand Agus	Melvin C. Gluck	Richard I. Levin	Michael F. Schloss
Edward L. Amorosi	Loren W. Greene	Jerome Lowenstein	Robert Silber
Manfred Blum	H. William Harris	Bruce J. Mack	Michael S. Simberkoff
Ronald Blum	Charles G. Hazz	Andrew M. Milano	Stephen A. Smiles
Morton A. Bosniak	Charles S. Hollander	Hal J. Mitnick	James L. Speyer
Mitchell H. Charap	Robert S. Holzman	Franco M. Muggia	Robert J. Spiegel
Paul G. Deutsch	Lawrence Horowitz	Valerie H. Peck	Norton Spritz
Martin Dolgin	Martin L. Kahn	Robert A. Press	Paul A. Tunick
Frederick Feit	Thomas G. Kantor	Marie Pulini	Fred T. Valentine
Martin S. Finkelstein	Irving Karten	James J. Rahal, Jr.	James C. Wernz
Michael L. Freedman	Lois A. Katz	David Ramsay	Stanford Wessler
Arthur C. Fox	David L. Kleinberg	Bruce G. Raphael	Howard E. Winer
Stuart M. Garay			

FEE: \$665

ACCREDITATION: 72 AMA Category I Credit Hours

Preregistration Form Course #302 INTERNAL MEDICINE BOARD REVIEW Please Print or Type

Name _____ Telephone No. () _____

Address _____
No. & Street City State Zip Code

Return with check payable to NYU Post Graduate Medical School

to: Registration Department, NYU Post-Graduate Medical School
Room 4-37-N LHB, 550 First Avenue, New York, N.Y. 10016
(212) 340-5295 (24-hour telephone)

☐ I need hotel information

- 24 The Spleen, Splenosis and Asplenic State**
8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(*St. Joseph's Hospital and AMNJ*)
- 24 Colony Forming Units: Laboratory and Clinical Applications**
7-9 p.m.—Coachman Inn, Cranford
(*NJ Blood Club and AMNJ*)
- Dec.**
- 1 Diabetes Update**
- 8 Infection in Compromise Host**
8-9 a.m.—Greater Paterson General Hospital
(*Greater Paterson General Hospital and AMNJ*)
- 2 Current Chemotherapy**
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 2 Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
- 2 Arthroscopy**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(*Columbus Hospital and AMNJ*)
- 2 Allergies for the Primary Care Physician**
1:30-2:30 p.m.—Rutgers Community Health Plan, New Brunswick
(*Rutgers Community Health Plan and AMNJ*)
- 2 Monthly Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section of AMNJ*)
- 2 Vitamins—Facts and Fictions**
- 16 Scientific Basis for Control of Environmental Diseases**
9:30-11:30 a.m.—Dover General Hospital
(*Dover General Hospital and AMNJ*)
- 2 Sleep, Circadian Rhythm and Cardiovascular Disease**
- 9 Pitfalls and Problems of Measuring Blood Pressure**
- 16 Osteoporosis and Osteomalacia**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 2 Acute and Chronic Kidney Failure**
- 9 Update of Esophageal Disorders**
- 23 The Diabetic Foot**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 2 Endocrine Conferences**
3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center, College Hospital, Newark and VA Medical Center, East Orange
(*Endocrine Section and AMNJ*)
- 9 Laboratory Findings in Adolescents**
9 a.m.—Freehold Area Hospital
(*AMNJ*)
- 3 Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(*Endocrinology Section of AMNJ*)
- 3 Hypoglycemia**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 3 Skin and Connective Tissue**
- 10 Excretory System**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)
- 4 Medical Grand Rounds**
11:30 a.m.—College Hospital, Newark
(*Endocrinology Section of AMNJ*)
- 4 Pulmonary Emboli**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 8 Proper Use of Endoscopy**
8 p.m.—Burdette Tomlin Memorial Hospital, Cape May Courthouse
(*AMNJ*)
- 9 Portal Hypertension**
- 16 Glomerular Disease of the Kidney**
1-2:30 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 11 Vasculitis**
8:30-9:30 a.m.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)
- 15 Urology**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 15 Acute Bowel Infarction**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 18 Eclampsia (DIC)**
12 noon—Freehold Area Hospital
(*AMNJ*)
- NEUROLOGY/PSYCHIATRY**
- Nov.**
- 2 Sleep Phobia in an 11-Year-Old Child**
8-10 p.m.—192 Chittenden Road, Clifton
(*Essex Psychiatric Seminar and AMNJ*)
- 3 Psychiatric Case Conference**
- 10 7:30-9:30 a.m.—Trenton Psychiatric Hospital**
(*Trenton Psychiatric Hospital and AMNJ*)
- 4 Tardive Dyskinesia**
- 18 Drug Abuse**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Hospital and AMNJ*)
- 4 Child Psychiatry Case Conference**
- 11 8:30-10:30 a.m.—Trenton Psychiatric Hospital**
(*Trenton Psychiatric Hospital and AMNJ*)
- 25 Lewis H. Loeser Memorial Lecture**
8-10:30 p.m.—South Orange Jr. High School
(*Mental Health Association of Essex County and AMNJ*)
- 5 Pediatric Developmental Diagnosis**
3:30-7:45 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 5 Psychotropic Medications/Psychiatric Complications of Non-psychiatric Medications**
- 19 Panic Attacks: Cause and Effects**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 5 Hypnosis in Medicine and Other Allied Professions**
3:30-7:30 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- Belle Mead**
(*Carrier Foundation and AMNJ*)
- 6 Psychiatric Lecture Series**
1:30-5 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 10 Psychopharmacology**
2 p.m.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)
- 14 The Psychological Aspects of Breast Cancer**
1:30 p.m.—Holy Name Hospital, Teaneck
(*American Cancer Society, Bergen County, Holy Name Hospital and AMNJ*)
- 18 Treating and Understanding Schizophrenic Patients**
1:30 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 19 Musculo-Skeletal System—Exercise Physiology**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)
- Dec.**
- 1 In-Patient Psychiatry**
- 9 Family Life Cycle**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonton
(*Ancora Psychiatric Hospital and AMNJ*)
- 8 Psychiatric Case Conferences**
7:30-9:30 a.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 2 Child Psychiatry Case Conferences**
9:30-10:30 a.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital*)
- 3 Hypnosis in Medicine and Allied Professions**
3:30-7:30 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 4 Psychiatric Lecture Series**
1:30-5 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 5 Alcoholics Anonymous and Psychiatry**
9:15 a.m.-4:30 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 7 Followup Presentation of Pathological Diseases**
8-10 p.m.—4 Garden Place, Nutley
(*Essex Psychiatric Seminar and AMNJ*)
- 8 Organic Basis for Mental Illness**
2 p.m.—Ancora Psychiatric Hospital, Hammonton
(*AMNJ*)
- 8 Laboratory Interpretations**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 9 Biochemistry of Depression and Its Application to Psychiatric Practice**
8:30-10:30 p.m.—Guido's Restaurant, Hackensack

CARDIOLOGY UPDATE . . .

is designed for the Internist/Cardiologist, which provides an intensive survey of the current status of Clinical Cardiology

**WEDNESDAY,
NOVEMBER 4, 1981**

20 Minutes Lectures—Questions and Answers (10 minutes)

MODERATOR: BERNARD L. SEGAL, M.D.

Calcium-Channel Blocking Agents and Angina Pectoris

Bernard L. Segal, M.D.

Streptokinase in Acute Evolving Myocardial Infarction

Charles E. Bemis, M.D.

The Approach to the Resuscitated Patient: Case Presentation and Discussion

Leonard N. Horowitz, M.D.

The Use of Verapamil in Supraventricular Tachycardia

Scott R. Spielman, M.D.

Case Presentation: Discussion

Ronald Pennock, M.D.

**3:00 PM—2nd floor New College Building,
Hahnemann
Medical College and Hospital**

- NO REGISTRATION FEE
- NO ADVANCE REGISTRATION REQUIRED
- CME CATEGORY I CREDITS CERTIFIED
- WINE & CHEESE SERVED AT 5:30 PM •

For further information, please call (215) 448-8063

NINTH SEMINAR AND WORKSHOP IN ACUPUNCTURE AND PAIN CONTROL

Sponsored by:
**NEW YORK SOCIETY OF ACUPUNCTURE
FOR PHYSICIANS & DENTISTS, INC.
AMERICAN COLLEGE OF
ACUPUNCTURE, INC.
AMERICAN ACADEMY OF
ACUPUNCTURE, INC.**

Co-Sponsored by:
**NEW YORK UNIVERSITY
POST-GRADUATE MEDICAL SCHOOL
NEW YORK UNIVERSITY
COLLEGE OF DENTISTRY**

November 20, 21, 22, 1981

New York University College of Dentistry

Accreditation: As an organization accredited for continued medical education, the New York University Post-Graduate Medical School certifies that this continuing medical education offering meets the criteria for 30 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Course Description: Chronic pain, including chronic facial pain, is among the most difficult of challenges to confront the practicing clinician. In the management of chronic pain, acupuncture is a most valuable tool when properly applied. This course, presented by authorities who have long been outstanding in the field, is designed to provide an update on the role of acupuncture, including laser acupuncture, in pain control, as well as in the clinical applications. Essential information and techniques will be presented for advanced as well as beginner students, and the course will include patient presentations and clinical instruction in the use of acupuncture. The course is approved by the New York State Boards for Medicine and Dentistry for 30 credit hours towards the State acupuncture certification requirement. Faculty consists of prominent clinicians and researchers from the People's Republic of China and the United States including: Yuan Shuo, MD, Head of the Department of Chinese Medicine, Third Teaching Hospital of Beijing Medical College, Beijing, China; Arthur Battista, MD, Professor of Neurosurgery NYU College of Medicine; Kathleen Foley, MD, Associate Professor of Neurology, Cornell University Medical College; David Mayer, PhD, Professor, Department of Physiology, Medical College of Virginia; and Gavriel Pasternak, MD, PhD, Assistant Professor of Neurology and Pharmacology, Cornell University Medical College. For further information and application please write: Shyh-Jong Yue, MD, Secretary, New York Society of Acupuncture for Physicians & Dentists, Inc., 115 East 61st Street, New York, NY 10021 or call Sandra Stanton at (212) 870-6153, Mon. to Fri., 11 AM to 3 PM or leave your name and full address on tape at (212) 876-9781.

(North Jersey Psychiatric Society and AMNJ)

9 Update on Drug Addiction

1:30 p.m.—Trenton Psychiatric Hospital
(AMNJ)

9 Self-help Treatment Programs

9:15 a.m.-4:30 p.m.—Center for Health Affairs, Alexander Rd., Princeton
(Carrier Foundation and AMNJ)

10 Medical Student Training in Psychiatry

12 noon-1 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

16 EEG Technology and Practice Series

7-9 p.m.—Middlesex General Hospital, New Brunswick
(EEG Society of NJ and AMNJ)

16 Psychosis, Differential Diagnosis and Management

1:30-3:30 p.m.—Trenton Psychiatric Hospital
(Trenton Psychiatric Hospital and AMNJ)

OBSTETRICS/GYNECOLOGY

Nov.

14 Update on the Care of the Female Patient for Primary Physicians

9 a.m.-5 p.m.—Stevens Institute of Technology, Hoboken
(Hudson County Medical Society and AMNJ)

24 The Exercising Female—Physiological and Pathological Aspects—Pregnant and Non-Pregnant Women

12 noon—Freehold Area Hospital
(AMNJ)

Dec.

16 Ovarian Cancer

1:30-2:30 p.m.—Rutgers Community Health Plan-57 U.S. Hwy., New Brunswick
(Rutgers Community Health Plan and AMNJ)

17 Reproductive System

4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(Institute for Medical Research and AMNJ)

PATHOLOGY

Nov.

14 The Influence of Pathologic Factors in Breast Cancer Management

9 a.m.—Holy Name Hospital, Teaneck
(American Cancer Society, Bergen County, Holy Name Hospital and AMNJ)

25 Clinical Pathology Conference

9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

Dec.

30 Clinical Pathology Conference

9:30-11:30 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

PEDIATRICS

Nov.

5 Pediatric Developmental Diagnosis

3:30-7:45 p.m.—Carrier Foundation, Belle Mead
(Carrier Foundation and AMNJ)

18 Hemoglobinopathies, Pediatrics

1:30-2:30 p.m.—Rutgers Community Health Plan, New Brunswick
(Rutgers Community Health Plan and AMNJ)

24 The Spleen, Splenosis and Asplenic State

8:30-10:30 a.m.—St. Joseph's Hospital, Paterson
(St. Joseph's Hospital and AMNJ)

Dec.

10 Pediatric Developmental Diagnosis

3:30 p.m.-7:45 p.m.—Carrier Foundation
(Carrier Foundation and AMNJ)

11 Lecture Series—Pediatric Subspecialties

8:15 a.m.-9:45 a.m.—Overlook Hospital, Summit
(Overlook Hospital, Columbia University College of Physicians & Surgeons and AMNJ)

21 Antenatal Detection of Genetic Disorders

12 noon-1 p.m.—Mountainside Hospital, Montclair
(Mountainside Hospital and AMNJ)

RADIOLOGY

Nov.

7 Real-Time, Cross-Sectional Sector

8 Scanning

9 a.m.-5 p.m.—Nassau Inn, Princeton
(The National Foundation for Non-Invasive Diagnostics and AMNJ)

14 Radiography and Ultrasonography in

Early Diagnosis of Breast Cancer
9:30 a.m.—Holy Name Hospital, Teaneck

(American Cancer Society, Bergen County, Holy Name Hospital and AMNJ)

14 Radiation Therapy as Primary Modality in Breast Cancer

3 p.m.—Holy Name Hospital, Teaneck
(American Cancer Society, Bergen County, Holy Name Hospital and AMNJ)

Dec.

16 Nuclear Medicine and the Kidney

9-11 a.m.—Roosevelt Hospital, Menlo Park
(Middlesex General Hospital and AMNJ)

23 Use of Computed Tomography in Stroke

9:30-11:30 a.m.—Bergen Pines County Hospital, Paramus
(Bergen Pines County Hospital and AMNJ)

GENERAL SURGERY

Nov.

12 Tumor Conference

12 noon-1 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

14 Breast Cancer-1981

8:30 a.m.-4:30 p.m.—Holy Name Hospital, Teaneck
(American Cancer Society, Bergen County, Holy Name Hospital and AMNJ)

2 Endocrine Surgery

1 p.m.—Christ Hospital, Jersey City
(AMNJ)

10 Tumor Conference

12 noon-1 p.m.—West Hudson Hospital, Kearny
(West Hudson Hospital and AMNJ)

15 Progress in Urology

8-10 p.m.—Englewood Club, 115 East Palisade Ave., Englewood
(Englewood Surgical Society, Englewood Hospital and AMNJ)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

Nov.

18 Carotid Artery Surgery

9:30-11:30 a.m.—Dover General Hospital
(Dover General Hospital and AMNJ)

18 Computerized Tomography

8-10 p.m.—391 White Oak Ridge Rd., Short Hills
(NJ Medical Women's Association and AMNJ)

24 Recent Advances in Laparoscopy

8-10 p.m.—Englewood Club, 115 East Palisade Ave., Englewood
(Englewood Surgical Society, Englewood Hospital and AMNJ)

Dec.

4 Update on Plastic Surgery

8:30-9:30 a.m.—United Hospitals Medical Center, Newark
(United Hospitals Medical Center)

MISCELLANEOUS

Nov.

11 The Patient's Bill of Rights and Physician Conduct in Hospital

1 p.m.—Christ Hospital, Jersey City
(AMNJ)

24 Malpractice

8 p.m.—Warren Hospital, Phillipsburg
(AMNJ)

Workshop entitled "Marriage, Divorce, and Sexual Counseling in Medical Practice," December 11-13, Rye Town Hilton, Port Chester, NY 10573 (13 hrs.; E, AAFP). Contact: Dr. Thomas M. Pick, 474 Main St., Greenfield, MA 01301; (413) 773-7983.

**The Academy of Medicine of New Jersey
The New Jersey Rehabilitation Hospital**

**Present a Symposium On
BRAIN TRAUMA MANAGEMENT:
A QUEST FOR SOLUTIONS**

**on
Friday & Saturday
November 6 & 7, 1981
Starts 9:00 A.M.**

**at
The Meadowlands Hilton, Secaucus**

The program will include presentations by nationally prominent speakers on acute care management, medical complications, cognitive levels, motor planning, characteristics and treatment, and therapeutic intervention. The program will offer a multi-disciplinary approach.

**For further information, please contact:
Executive Offices
Academy of Medicine of New Jersey
Two Princess Road
Lawrenceville, NJ 08648
Phone: (609) 896-1717**

**THIRD ANNUAL
MINIRESIDENCY
IN OCCUPATIONAL MEDICINE**



**COLLEGE OF MEDICINE AND
DENTISTRY OF NEW JERSEY**

**DEPT. OF ENVIRONMENTAL AND COMMUNITY MEDICINE
RUTGERS MEDICAL SCHOOL
PISCATAWAY, NEW JERSEY 08854**

DATE:
March 8 - 26, 1982/15 weekdays

PURPOSE:
To provide a background in Occupational Health. To aid in obtaining board eligibility and certification. To teach what was not taught in medical school. To bring you the latest advances.

ACCREDITATION:
The College of Medicine and Dentistry of New Jersey-Office of Continuing Education certifies that this continuing medical education activity meets the criteria for 90 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association, provided the program is completed as designed.

SUBJECTS:
Epidemiology and Statistics, Toxicology - Neurotoxicity, Industrial Hygiene, Occupational Diseases (Dermatology, Ophthalmology, Psychiatry), Infectious Diseases, Immunology, Hepatology - Nephrology, Public Health Administration, Medical Department Administration, Ergonomics, The Woman in the Workplace, Disability Evaluation - Stress Testing, Ionizing Radiation.

TUITION.
\$1195. for full course/\$190. for selected sessions of 2 days.

FOR INFORMATION CONTACT
J. Lieben, M.D. at above address or call

201-463-4772

Dr. Robert E. Farabaugh

The former director of the department of obstetrics and gynecology at Clara Maass Memorial Hospital in Belleville, Robert E. Farabaugh, M.D., died on July 31 at Point Pleasant Hospital. A native of Pennsylvania, Dr. Farabaugh was graduated from the Long Island College of Medicine in 1943 and pursued residencies at Kings County Hospital, New York and St. Michael's Medical Center, Newark, earning board certification in obstetrics and gynecology and fellowship in the American College of Obstetricians and Gynecologists and in the American College of Surgeons. In addition to his duties at Clara Maass Hospital, he had been on the staff at St. Michael's Medical Center and at St. Mary's Hospital in Passaic. During World War II, Dr. Farabaugh served with the medical department of the AUS. He had retired in 1976 and was living in Bricktown. Dr. Farabaugh was 71 years old at the time of his death.

Dr. Anthony R. Garzieri

One of Passaic County's senior members, Anthony R. Garzieri, M.D., died at his home in Franklin Lakes on July 29. Born in 1909 in Cairo, Egypt, Dr. Garzieri was graduated from the Laval University Medical College in Quebec (Canada), class of 1943, and took residencies in obstetrics and gynecology at Paterson General Hospital, Jersey City Medical Center and Bellevue Hospital in New York. He was a Fellow of the American College of Obstetricians and Gynecologists and of the International College of Surgeons. Dr. Garzieri had been affiliated with the Memorial Hospital in Fair Lawn, Paterson General Hospital and the Valley Hospital in Ridgewood. During World War II, he served with the medical department of the AUS.

Dr. Louis F. Harter

At the grand age of 86, Louis F. Harter, M.D., a member of our Hudson County component, died in Christ Hos-

pital, Jersey City on July 19. A native of Pittston, Pennsylvania, Dr. Harter was graduated from Fordham University College of Medicine, class of 1919, and pursued a career in surgery and proctology. He was a Fellow of the American College of Surgeons and had been affiliated with the Christ Hospital and the Medical Center in Jersey City and St. Mary's Hospital in Hoboken. In 1969, Dr. Harter received MSNJ's Golden Merit Award indicating fifty years in medical practice. He had retired some years ago and was living in Pompano Beach, Florida.

Dr. Sandor Levinsohn

Sandor Levinsohn, M.D., formerly of Paterson (where he had practiced for over 50 years) and a member of our Passaic County component, died on August 3 in San Francisco. A native of New York City, Dr. Levinsohn was graduated from Bellevue Hospital Medical College in 1918 and pursued a career in pediatrics, becoming board certified in that specialty and earning Fellowship in the American Academy of Pediatrics. He had been affiliated with St. Joseph's Medical Center and Barnert Memorial Hospital in Paterson. Dr. Levinsohn was a recipient of MSNJ's Golden Merit Award in 1968, marking 50 years as a physician. He retired on January 1, 1976 and had been living in West Palm Beach, Florida. Dr. Levinsohn was 84 years old at the time of his death.

Dr. Rafael G. Morales

On July 28 Rafael G. Morales, M.D., of Greystone Park, died in Morristown Memorial Hospital as a result of a brutal beating the week before. Born in 1919 and a native of Havana, Cuba, Dr. Morales earned his medical degree from the National University of Mexico Medical School in 1958 and took residencies in psychiatry at New York Polyclinic Medical School in New York City and the New Jersey State Hospital at Greystone Park where he was affiliated at the time of his death. Dr. Morales was a member of our Morris County component.

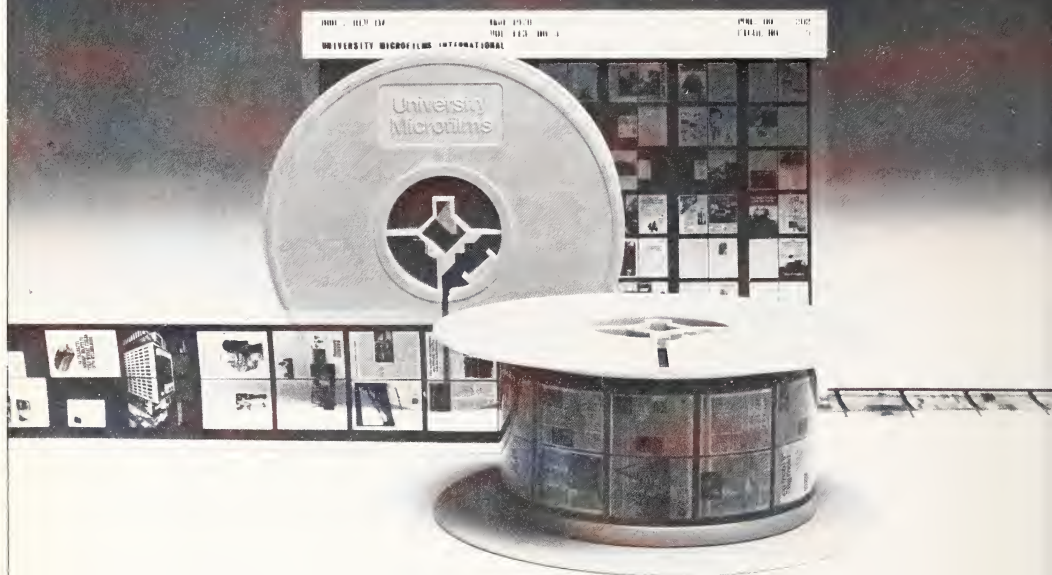
Dr. Henry A. Terwedow

A member of our Hudson County component, Henry A. Terwedow, M.D., of North Bergen, died on July 29 at his home. A native of Jersey City, born in 1914, Dr. Terwedow was graduated from New York Medical College in 1941 and established a practice in general medicine in North Bergen and later directed his activity to internal medicine with special interest in diabetes. Dr. Terwedow was affiliated with St. Mary's Hospital in Hoboken. He was a member of the New Jersey affiliate of the American Diabetes Association. During World War II Dr. Terwedow served with the medical department of the AUS.

Dr. John Zaorski

At the untimely age of 47, John R. Zaorski, M.D., a clinical assistant professor of thoracic surgery at New Jersey Medical College, CMDNJ, died on August 1 at Valley Hospital, Ridgewood, where he was a staff member. He was chief of thoracic surgery at Holy Name Hospital in Teaneck and cardiovascular surgeon at Hackensack Medical Center, and was affiliated also with Bergen Pines County Hospital in Paramus and St. Barnabas Medical Center in Livingston. He was graduated from New Jersey Medical College, class of 1960, and took residencies at Hackensack Hospital, Manhattan Veterans Administration Hospital in New York and Pollak Hospital in Jersey City, becoming board certified in both surgery and thoracic surgery. He was a Fellow of the American College of Thoracic Surgeons and of the American College of Angiology. Dr. Zaorski had served a fellowship with Dr. Denton Cooley in Houston and last year was president of the Denton A. Cooley Cardiovascular Surgical Society, an international organization of more than 300 surgeons. During the Korean Conflict, Dr. Zaorski was chief of general and thoracic surgery at an evacuation hospital in Ascom, Korea and was stationed also with a mobile surgical hospital in another area.

This publication is available in microform.



University Microfilms International

Please send additional information for _____
(name of publication)

Name _____

Institution _____

Street _____

City _____

State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

THE JOURNAL OF MEDICAL SOCIETY OF NEW JERSEY

Publisher: Medical Society of New Jersey
Two Princess Road
Lawrenceville, N.J. 08648

Advertising Representative: United Media Associates
(pharmaceutical) 16 Bruce Park Avenue
Greenwich, Conn. 06830
(203) 661-9702

General Information

1. Issuance:

- a. Frequency: Monthly
- b. Issue date: 10th of month.
- c. Mailing date: 10th of month.

2. Established: 1904

3. Organization Affiliation:

Official publication
Medical Society of New Jersey.

4. Circulation Data:

- a. Controlled circulation to all members of Medical Society of New Jersey. Member's subscription (\$10) is included in Society dues. Rates for nonmembers \$20, outside USA add \$7.50 for postage. Single copies \$2.
- b. Annual percentage of subscription renewals: 100% of members.
- c. Number of copies sent after subscription expiration: None.

5. Special Issue:

Index (December)

6. Editorial Content:

Scientific articles, special articles, case reports, editorials, medical news and meeting notices, trustees' minutes, state legislation, convention medical insurance, PSRO, education, CME, HMO's, Professional Liability Commentary, JEMPAC Reportorial, Review Articles, State-of-the-Art Articles, Commentary, The Electrocardiogram; Non-Invasive Cardiology, Nutrition Update, Pediatric Briefs, Therapeutic Drug Information, Clinical Note, Your Congressman Speaks, Doctors' Notebook, Letters to *The Journal*, Personal Items, Obituaries, Book Reviews, Medical Histories.

7. Requirement for Acceptance of New Professional Products for Advertising.

All advertising subject to Publication Committee approval.

8. Requirement for Advertising Clearance:

All advertising subject to Publication Committee approval.

9. Advertising Acceptance of Nonprofessional Products or Services:

All advertising subject to Publication Committee approval.

10. Policy on Placement of Advertising:

Advertising is interspersed throughout the publication. All R.O.B. ads are rotated each month. Advertising and editorial material is not placed on the same page.

11. Advertisers' Index:

No.

12. Services to Advertisers:

Availability of editorial reprints: Please direct such requests to the Managing Editor.

13. Staff

Editor: Arthur Krosnick, M.D.; Managing Editor: Marjorie D. Treptow; Executive Director: Vincent A. Maressa.

14. Circulation:

All members of Medical Society of New Jersey.

15. Guaranteed Circulation:

All members of Medical Society of New Jersey.

16. Circulation Verification:

Publisher's statement, postal receipt verification.

17. Rates Per Thousand:

Based on the 12-times rate of \$380.00 and circulation of 10,000: \$38.00.

The JOURNAL of Medical Society of NEW JERSEY

Rate Card effective January 1982

18. Coverage and Market

a. Coverage: All members of the Medical Society of New Jersey, plus trade circulation.

b. GP	2,790
IM	1,597
GS	1,222
OBG	693
PED	582
DERM	170
ALL	68
UROL	181
OTO	368
PSYCH	547
OPH	322
CARD	78
GASTRO	28
ANES	234
TOTAL	9,687

c. Trade Circulation:

Non-member physicians	
Medical libraries	
Medical schools	
Drug manufacturers	
Medical book publishers	
Medical abstract services	
Advertisers	
Advertising agencies	
Subscriptions	
Total approximately	650

d. Readership Survey: Readership surveys by Health Industries Research and FOCUS show that the JOURNAL is extremely well read. Copies are available upon request.

19. MEMBERSHIP CIRCULATION BY COUNTIES OF STATE OF NEW JERSEY

Atlantic	247
Bergen	1,124
Burlington	277
Camden	567
Cape May	49
Cumberland	131
Essex	1,765
Gloucester	109
Hudson	557
Hunterdon	69
Mercer	569
Middlesex	600
Monmouth	550
Morris	516
Ocean	283
Passaic	725
Salem	52
Somerset	185
Sussex	75
Union	858
Warren	64
Total	9,372

Guaranteed Circulation: 10,000

The JOURNAL of Medical Society of NEW JERSEY

Rate Card effective January 1982

Rates

20. Issuance:

- Frequency: Monthly
- Issue Date: 10th of month
- Mailing Date: 10th of month.

21. Closing Dates for Space:

- Reservations: 1st of month preceding month of issue
- Cancellations: 6th of month preceding month of issue

22. Agency Commission:

15%

23. Cash Discount:

2%, 10 days.

24. Rates:

	1 time	3 times	6 times	12 times	
1 page	420	410	400	380	Classified: Available to member physicians only
1/2 page	215	205	200	190	
1/4 page	105	100	98	96	
1/8 page	65	60	55	50	

25. Earned Rates:

Rates based on number of insertions used within one year, regardless of size. Space purchased by a parent company and subsidiaries is combined for accounting of earned rates.

26. Color Rates:

- Standard color \$150 plus earned black and white rate.
- List of standard colors: AAAA standard red, green, blue, yellow, orange.
- Matched Colors: \$180 plus earned black and white rate.
- 4-color rate: \$500 plus earned black and white rate.

Special 4-color rates are available to advertisers placing insertions in the Five Key State Journals (Illinois, New Jersey, New York, Ohio and Pennsylvania). Contact UMA.

27. Bleed

No bleed charge.

28. Inserts:

60 pound coated only.

2 page furnished inserts—2x b/w rate; 4 page furnished inserts—4x b/w rate.

29. Preferred Position Rates:

- Preferred position rates quoted on request and subject to availability.
- Should an advertiser insist on a specific position, production requirements may dictate premium rates.

30. Miscellaneous:

- Contract requirements: All contracts subject to publisher's approval.
- Statement of guarantee of uniform rates and discounts to all advertisers using same amount and kind of space: No exceptions to published rates.
- Concessions: None
- Rates subject to change with 90 days notice. Contracts accepted with understanding that rates will be guaranteed for three months beyond last issue closed. In the event of rate increase, contracts may be terminated without penalty of short rate.

The JOURNAL of Medical Society of NEW JERSEY

Rate Card effective January 1982

Mechanical Requirements

THE JOURNAL is printed by offset.

Trim size: 8 x 11

31. Plate Sizes:

Page Unit	Dimensions
1 full page	7 x 10
1/2 horizontal	7 x 4-7/8
1/2 vertical	3-3/8 x 10
1/4 vertical	3-3/8 x 4-7/8
1/8 vertical	3-3/8 x 2-3/8

32. Bleed Sizes:

Page Unit	Dimensions
1 full page	8-1/8 x 11-1/4
1/2 horizontal	8-1/8 x 5-5/8
1/2 vertical	11-1/4 x 4-1/16

33. Insert Requirements:

Untrimmed size—8-1/4 x 11-1/4

Quantity—11,500

34. Paper Stock:

Covers: 80-pound. Inside pages: 60 or 50 pound.

35. Type of Binding:

Perfect bound.

36. Halftone Screen:

Up to 133 screen.

37. Reproduction Requirements:

Black and white positives and 2-color advertisements: negatives, camera-ready mechanicals, and art work acceptable.

4-color: film negatives or positive separations and press proof.

Offset film negatives or positives on .002 or .004 stable base materials must have register marks, center marks, and trim marks clearly indicated. Each negative must be marked for color and be right reading emulsion side down.

38. Closing Dates:

a. Negatives or positives, camera ready mechanicals, and art work: 10th of the month preceding month of issue.

b. Publication set copy: 5th of month preceding month of issue.

39. Disposition of Reproduction Material:

Material is held for one year and then destroyed.

40. "Dual Responsibility":

Billing directed to the advertising agency at the net rate is approved on condition that the advertiser will accept "dual responsibility" for payment if the agency does not remit within 90 days. Advertising accounts in arrears 60 days will be billed in duplicate to both the agency and the advertiser.

41. Addresses:

Pharmaceutical Sales:

United Media Associates
16 Bruce Park Avenue
Greenwich, Connecticut 06830
203-661-9702

Non-Pharmaceutical Sales, general information:

Cookson Media Services, Inc.
370 Morris Avenue
Trenton, N.J. 08611
609-393-7196

Contracts and insertion orders:

Journal of MSNJ
370 Morris Avenue
Trenton, N.J. 08611
609-393-7196

Reproduction material:

Journal of MSNJ
Two Princess Road
Lawrenceville, N.J. 08648
609-393-7196

Inserts: (11,500)

Journal of MSNJ
c/o Hughes Printing Company
34 North Crystal
East Stroudsburg, Pa. 18301

CLASSIFIED ADVERTISEMENTS

CARDIOLOGIST—Desires group or partnership practice in Cardiology or Cardiology Internal Medicine, invasive and/or non-invasive. University trained. ABIM, board eligible in cardiology. Write Box No. 271, c/o JOURNAL MSNJ.

FAMILY PRACTITIONER—Board eligible. Desires group. Penn State Hershey graduate 1979. Available August 1982. Write Box No. 272, c/o JOURNAL MSNJ.

INTERNIST—Cardiologist, young, interested in joining practice in New Jersey. Strong university training. Board certified in internal medicine. Extensive experience clinical, invasive and non-invasive cardiology. A. Losardo, M.D. (212) 645-5190.

INTERNIST—Training and experience in hematology/oncology. ABIM, U of P Med. Wishes to associate or buy. Write Box No. 241, c/o JOURNAL MSNJ.

INTERNIST—ABIM, 30 years old, practicing NYC. Seeks relocation to New Jersey. Will consider solo, partnership, share office. Call (212) 720-4003 evenings or weekend or write 412 Maryland Ave., #3C, Staten Island, NY 10305.

ONCOLOGIST/HEMATOLOGIST/INTERNIST—Board eligible, New York University trained. Seeking solo, group, partnership in New Jersey. Available July 1982. S.K. Mehrotra, M.D. 390 Maryland Ave., Apt. 3A, Staten Island, NY 10305. (212) 720-0798 after 6 p.m.

OTOLARYNGOLOGY—Board certified with broad experience. Seeking group, partnership; will consider solo. Available August 1982. Write Box 269, c/o JOURNAL MSNJ.

INFORMATION FOR MEMBERS—RATES—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance.
WORD COUNT: Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JOURNAL MSNJ" as six words. **COPY DEADLINE**: Fifth of preceding month.

RHEUMATOLOGIST-INTERNIST—ABIM, both with excellent clinical teaching/practice experience. Desires association with specialty group/partnership in New Jersey. Write Box No. 270, c/o JOURNAL MSNJ.

PEDIATRICIAN—To associate with another pediatrician. Excellent opportunity. Essex County. Write Box No. 266, c/o JOURNAL MSNJ.

INTERNIST—To buy established practice, or seeks solo, group or partnership. Board certified, 29, practicing two years. Desires to relocate in New Jersey. Available July 1982. Write Box No. 265, c/o JOURNAL MSNJ.

OPHTHALMOLOGIST—Wishes to purchase or associate with an Ophthalmology practice in New Jersey. Please contact Box No. 268, c/o JOURNAL MSNJ.

PEDIATRICIAN—Wishes to buy active practice in NJ or become associate with a pediatrician. Would also consider position in medical group. Board eligible, hospital affiliated. Write Box No. 267, c/o JOURNAL MSNJ.

PRACTICE FOR SALE—Englewood Hospital Area, Bergen County. Internal Medicine and Family Practice. Practice is large enough to support 2 physicians. Principals only. Building and equipment negotiable. Write Box No. 262, c/o JOURNAL MSNJ.

FOR SALE—PEDIATRIC PRACTICE—Pediatrician entering academic medicine. Thriving, varied practice, shore area. Opportunity to join as associate before acquisition. Practice easily expandable to two physicians. Purchase terms very negotiable. Write Box No. 258, c/o JOURNAL MSNJ.

WANTED—OFFICE EQUIPMENT—Examining tables and any other office equipment and supplies for use in general medical practice. Allan Lazar, M.D., P.O. Box J, Teaneck, NJ 07666. (201) 568-3742.

FOR SALE—Home/Office/Furnishings, due to death of GP. Small town location, N.W. New Jersey. Two hospitals nearby. Excellent opportunity for family practitioner or internist. Call (201) 689-1705.

FOR SALE—Home/Office/Practice. Beautiful home with office and practice. 396 North Arlington Avenue, East Orange, NJ 07017. Call Dr. Betty Sobol (201) 627-8018 evenings 7-10 p.m.

FOR SALE—Southern NJ. Fully equipped 8 room medical office with 2 rental apartments. In a doctor-shortage area close to Philadelphia. Phone Mrs. S. Lintz, (609) 467-0466 or write Box 157, Swedesboro, N.J. 08085.

OFFICE SPACE—Physician's office for rent, suburban area, on main road. Call (201) 887-7492 or (201) 887-1628 after 5 p.m.

OFFICE SPACE—Kenilworth. For rent in medical office. Call (201) 272-5750.

OFFICE SPACE—Montclair, 1200 feet, large waiting room, business office, three examining rooms. Commercial district, two blocks from Mountainside Hospital. Adequate parking. Call (201) 744-4941.

OFFICE SPACE—Northern NJ. Available one private exam room and share fully furnished waiting room, business office auxiliary exam room. Excellent exposure, close to hospital, near major hwy's, 30 minutes to NYC. Call evenings (201) 337-1627.

OFFICE SPACE TO SHARE—Downtown Summit. Common waiting room, own examination room. All day Wednesday, Friday afternoon. Call after 7 p.m. (201) 552-1020.

NEEMA EMERGENCY MEDICAL —a professional association—

Emergency Medicine Positions—available with emergency physician group in PA, NY, NJ, VA, WV, KY, MD and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:
 NEEMA Emergency Medical
 Suite 400 or phone
 399 Market Street in Pa., (215) 925-3511
 Philadelphia, Pa. 19106 outside Pa., 800-523-0776

SMALL TOWN/BIG CITY/GROWTH AREA. FAMILY PRACTITIONER to join group of 2 physicians and 2 physician assistants in small, S.W. Washington community. Take over established practice, share call equally. Guaranteed salary, leading to percentage of gross; early partnership available. Close (30 minutes) to Portland, Oregon and to a variety of metropolitan cultural and educational opportunities. Send reply with curriculum vitae to: John Rotchford, Manager, P.O. Box 1004, Camas, WA 98607 or call: 1-206-834-3141.

**GENERALISTS AND SPECIALISTS
PRIME OFFICE SPACE**

Rooms or suites immediately available. May be altered to suit. Parking on premises. Excellent location. *Urgent need for additional professionals* in this stable, hi-growth area with lg patient clientele. Plentiful ins. Excellent rental terms. NW N.J.

**Dr. Craig B. Gimbel, DDS-PA
201-728-7550**

JACKSON, NEW JERSEY

Office space to rent or share in center with two groups of obstetricians, one general surgeon, one nephrologist. Ideal for someone starting in practice.

Call 201-477-2727 or 201-892-9499

SOMERVILLE

professional office building one story—
excellent parking 2 blocks from
Somerset Hospital on main
thoroughfare. We will finish to suit
Suites from 1100 sq. ft.

**Knauer Realtycorp
201-526-7600**

**RESIDENCY IN
PHYSICAL MEDICINE
AND REHABILITATION**

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$17,500 to \$20,100 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

Physician's Suite in modern one-story professional building.

**CINNAMINSON
DENTAL-MEDICAL CENTER**

U.S. Route 130 and Wynwood Drive, Cinnaminson, N.J. (Across from Main Line Shopping Center and opposite Merion Caterers)

Doctor's office, two treatment rooms, receptionist's quarters including adequate space for patients' files and bookkeeping records. Large waiting room shared in common with three other doctors in partnership practice.

Includes all utilities, viz: gas, electricity, heat, air conditioning, hot water, trash removal and maid service, and large parking area used in common with other occupants of building.

Private Space	956 sq. ft.
1/3 of waiting room	177 sq. ft.
Total	1,133 sq. ft.

\$10.00 per square foot equals \$11,330 yearly or \$944 monthly.

No escalation or CPI adjustment during first two years of five-year lease. Inquire of:

**Leopold Mamolen, Agent,
Phone (609) 786-0534**

November 1981

Journal of
the Medical
Society of

New Jersey

Patient's Rights

Russell L. McIntyre, Th.D.

Euthanasia

Marvin S. Fish

Medical Ethics

James S. Todd, M.D.

Maternal Deaths in
New Jersey

James P. Thompson, M.D.

Complete Table of
Contents on page 794

The Library
Acquisitions Division
Univ. of Calif., San Francisco
San Francisco, Calif. 94143

LIBRARY
U.C. SAN FRANCISCO

NOV 24 1981

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

***Check this list
against your
coverages***

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$7,500 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____

There's more to **ZYLOPRIM[®]** than (allopurinol).



- From Burroughs Wellcome Co. – the discoverer and developer of allopurinol
- Patient starter/conversion kits available for easy titration of initial dosage
- Patient compliance pamphlets available
- Continuing medical education materials available for physicians



Prescribe for your patients as you would for yourself.

*Write "D.A.W.," "No Sub.," or "Medically Necessary,"
as your state requires, to make sure
your patient receives the original allopurinol.*



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766



November 1981

Officers and Trustees

PRESIDENT	Armando F. Goracci, M.D. (Gloucester)	Woodbury
PRESIDENT-ELECT	Howard D. Slobodien, M.D. (Middlesex)	Perth Amboy
FIRST VICE-PRESIDENT	Alexander D. Kovacs, M.D. (Union)	Scotch Plains
SECOND VICE-PRESIDENT	Frank Y. Watson, M.D. (Essex)	Montclair
IMMEDIATE PAST-PRESIDENT	Augustus L. Baker, Jr., M.D. (Morris)	Dover
SECRETARY	Arthur Bernstein, M.D. (Essex)	East Orange
TREASURER	Rudolph C. Gering, M.D. (Mercer)	Pennington

Trustees

CHAIRMAN	William Greifinger, M.D. (1984) (Essex)	Belleville
	Meyer L. Abrams, M.D. (1982) (Burlington)	Cherry Hill
	Frank Campo, M.D. (1984) (Mercer)	Trenton
	Douglas M. Costabile, M.D. (1984) (Union)	Murray Hill
	John J. Crosby, Jr., M.D. (1984) (Hudson)	Jersey City
	Anthony P. DeSpirito, M.D. (1982) (Monmouth)	Neptune City
	Ralph J. Fioretti, M.D. (1983) (Bergen)	Rochelle Park
	Palma E. Formica, M.D. (1984) (Middlesex)	Old Bridge
	Harry W. Fullerton, Jr., M.D. (1982) (Salem)	Carney's Point
	Sherman Garrison, M.D. (1983) (Cumberland)	Bridgeton
	John P. Kengeter, M.D. (1984) (Ocean)	Toms River
	Myles C. Morrison, Jr., M.D. (1982) (Morris)	Morristown
	Michael R. Ramundo, M.D. (1984) (Passaic)	Clifton
	Bernard Robins, M.D., (1983) (Essex)	Springfield

Councillors

FIRST DISTRICT		
(Essex, Morris, Union and Warren Counties)		
Edward M. Coe, M.D. (1984)	.....	Cranford
SECOND DISTRICT		
(Bergen, Hudson, Passaic and Sussex Counties)		
Robert A. Weinstein, M.D. (1983)	.....	Newton
THIRD DISTRICT		
(Hunterdon, Mercer, Middlesex and Somerset Counties)		
Albert F. Moriconi, M.D. (1982)	.....	Trenton
FOURTH DISTRICT		
(Burlington, Camden, Monmouth and Ocean Counties)		
Frederick W. Durham, M.D. (1984)	.....	Haddonfield
FIFTH DISTRICT		
(Atlantic, Cape May, Cumberland, Gloucester and Salem Counties)		
Ronald M. Fisher, M.D. (1983)	.....	Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982)	Hackensack
William J. D'Elia, M.D. (1981)	Spring Lake
Frederick W. Durham, M.D. (1982)	Haddonfield
Karl T. Franzoni, M.D. (1982)	Trenton
John S. Madara, M.D. (1982)	Salem
Henry J. Mineur, M.D. (1982)	Cranford
Myles C. Morrison (1981)	Morristown

Publication Committee

Paul J. Hirsch, M.D., <i>Chairman</i>
Dirck L. Brendlinger, M.D.
Julio C. del Castillo, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

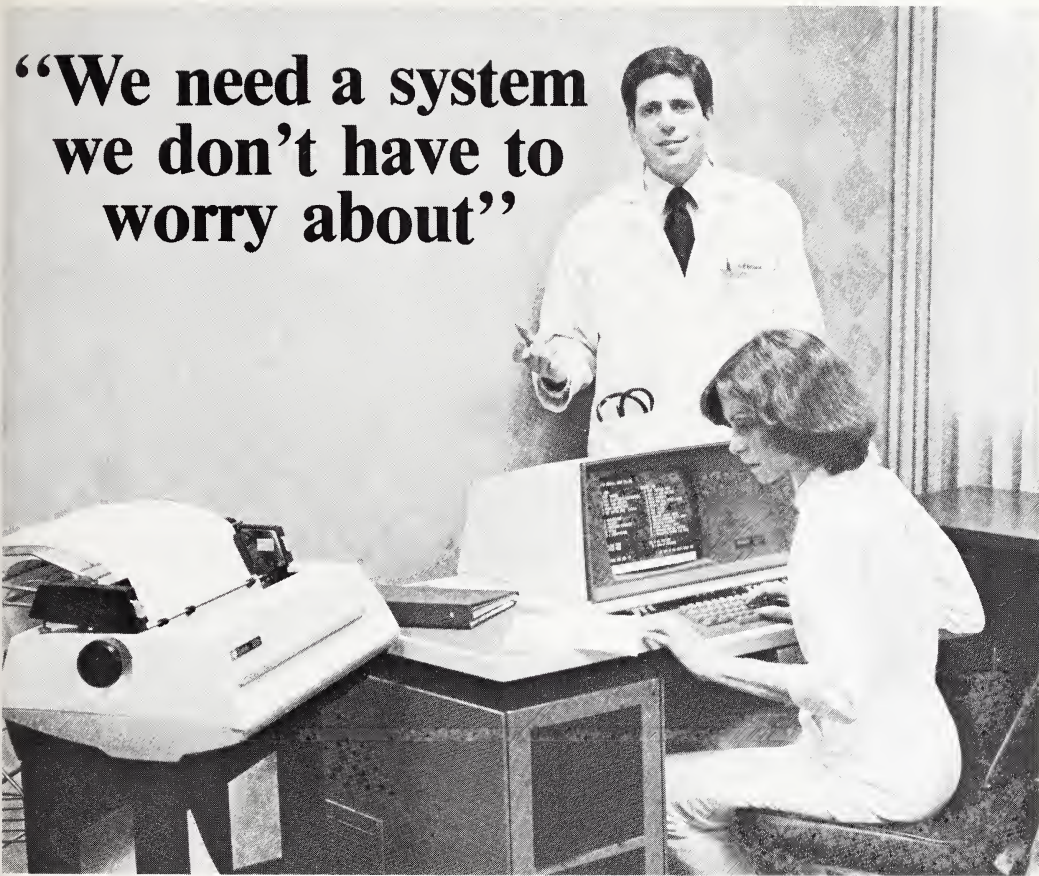
Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.
Harold Arlen, M.D.
Alfonse Cinotti, M.D.
Stuart D. Cook, M.D.
Robert Dodelson, M.D.
Wm. A. Dwyer, Jr., M.D.
Norman H. Ertel, M.D.
A. Olusegun Fayemi, M.D.
Arthur Goldfarb, M.D.
Robert A. Goldstone, M.D.
Murray Kahn, M.D.
Monroe S. Karetzky, M.D.
Avrum L. Katcher, M.D.
Sidney Ketyer, M.D.
Bernard J. Koven, M.D.
Joel D. Levinson, M.D.
Henry R. Liss, M.D.
Robert M. MacMillan, M.D.
Geobel A. Marin, M.D.
Christopher M. Papa, M.D.
Victor Parsonnet, M.D.
Irwin Pollack, M.D.
Bernard A. Rineberg, M.D.
Edwin L. Rothfeld, M.D.
Benjamin F. Rush, Jr., M.D.
Morris H. Saffron, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Sheldon D. Solomon, M.D.
Lloyd N. Spindell, M.D.
A. Arthur Sugerman, M.D.
Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 930. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

“We need a system we don’t have to worry about”



Dr. I. David Weisband, of the Regional Orthopedic Professional Association, is one of a growing number of physicians who've found Minicom's Medical Practice Management System meets the unique needs of a medical practice.

Automatic preparation of statements, Medicare and insurance company forms; instantaneous, up-to-the-minute accounts receivable information, plus a variety of practice analysis reports.

“We treat patients, not computers,” Dr. Weisband says, “so we need a system we don’t have to worry about.”

And our Medical Practice Management System is just that. It

features reliable Xerox Diablo equipment and is backed by our policy of Unsurpassed Service—hardware, software, training, maintenance and system back-up, all from one reliable source.

“Our office manager and accounting firm investigated alternatives,” he continues, “and recommended the Minicom system as the best solution to our needs. I agree.”

So, before you invest in a computer system for your practice, take his advice. Look into our Medical Practice Management System. Drop the coupon in the mail, or give us a call...and ask about US!

I'd like more information on Minicom's Medical Practice Management System.

Name

Address

City, State, Zip

Telephone (Area Code) MNJ



MINICOM

1415 E. Marlton Pike,
Cherry Hill, N.J. 08034
(609) 429-0600
(215) 925-6908

UNSURPASSED SERVICE

Distributors of Xerox business and professional computer systems.

Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

800 **PROFESSIONAL LIABILITY COMMENTARY**

EDITORIALS

803 The Physician in Today's Society

804 Anxiety and Action

806 **JEMPAC REPORTORIAL**

ARTICLES

809 Patient's Rights: Where Are We? Where Are We Going?

Russell L. McIntyre, Th.D., Piscataway

812 Euthanasia: Where Are We? Where Are We Going?

Marvin S. Fish, Newark

816 Medical Ethics: Where Are We? Where Are We Going?

James S. Todd, M.D., Ridgewood

819 Current Patterns of Acute Renal Failure

Anthony A. Donatelli, M.D., Plainfield

825 Maternal Deaths in New Jersey—1979

James P. Thompson, M.D., Paterson

STATE OF THE ART

829 Endoscopy and Upper Gastrointestinal Tract Bleeding

Joel D. Levinson, M.D.; Michael B. Kerner, M.D., Springfield

CASE REPORT

832 *Listeria Monocytogenes* Meningitis in Infant of Habitual Aborter

Jeremias L. Murrillo, M.D.; Jules A. Titelbaum, M.D., Newark

NUTRITION UPDATE

834 Bulimia and Vomiting Syndrome

Alexander R. Lucas, M.D., Rochester, Minnesota

836 **PEDIATRIC BRIEFS**

839 **OWNERSHIP STATEMENT**

DOCTORS' NOTEBOOK

840 CMDNJ Notes

841 MSNJ Auxiliary

841 Physicians Seeking Location in New Jersey

845 **LETTER TO THE JOURNAL**

846 **LETTERS OF INTEREST**

847 **CME CALENDAR**

851 **ANNUAL MEETING DAILY SCHEDULE**

852 **OBITUARIES**

854 **BOOK REVIEW**

Cover

The cover photograph, by Joyce Heisen of Yardley, Pennsylvania, is a black and white print of a still life which originally was photographed on color slide film.



When are Inpatients Outpatients? When they're in Recreational Therapy.

If you live within a 50-mile radius of our hospital, you've probably seen our specially constructed "Ironsides" van on its way to, or coming back from, a ballgame, theater, or shopping center.

Teaching patients to have fun is serious business for our Recreational Therapists and on most weekends and evenings Terry May (seen above), Joanne Fishman, or one of our other therapists, drives a small group of disabled people back into the outside world of the able-bodied.

Fun and games and a return to society are essential parts of a total rehabilitation program.



New Jersey Rehabilitation Hospital

Owned and operated by Moderncore Centers of America, Inc.

240 Central Avenue, East Orange, NJ 07018 • 201-673-1860

Bertrand J. Bensam, MD, Medical Director • Stanley Shepard, Administrator

Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities and the American Board for Certification in Orthotics and Prosthetics Inc.

Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white

glossy prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source, written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp. 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

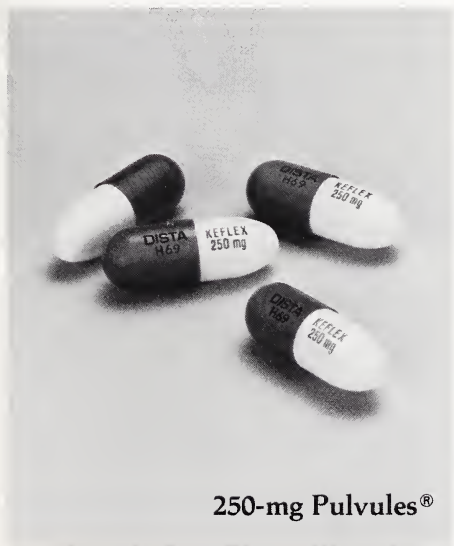
REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

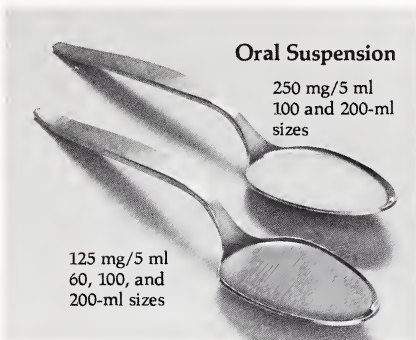
COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.

easy to take



250-mg Pulvules®



Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes



Pediatric Drops

100 mg/ml
10-ml size

Keflex®

cephalexin

Additional information available
to the profession on request.



Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

BactrimTM

(trimethoprim and sulfamethoxazole)

succeeds

ROCH

Expanding its usefulness in antimicrobial therapy

—**recurrent urinary tract infections**

due to susceptible *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *P. vulgaris* and *P. morgani*

—**pyelonephritis**

due to susceptible organisms

—**acute otitis media in children**

due to susceptible *H. influenzae* or *S. pneumoniae*

—**acute exacerbations of chronic bronchitis in adults**

due to susceptible *H. influenzae* or *S. pneumoniae*

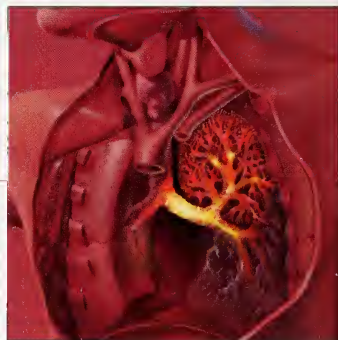
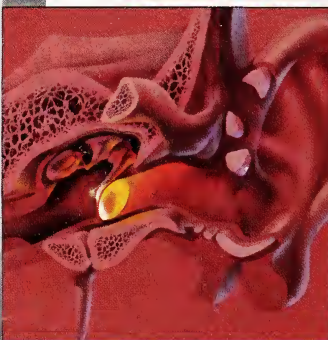
—**documented *Pneumocystis carinii* pneumonitis**

To date, Bactrim has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy

—**shigellosis**

due to susceptible *Shigella flexneri* or *S. sonnei*

Contraindicated during pregnancy at term and the nursing period, in infants less than 2 months of age, in patients hypersensitive to its components, and in those with documented megaloblastic anemia due to folate deficiency



Bactrim™

(trimethoprim and sulfamethoxazole)

A major antimicrobial with multisystem usefulness.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available indicates effectiveness of treatment of otitis media with Bactrim when infection is due to penicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

For the treatment of documented *Pneumocystis carinii* pneumonia. To date, the drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL (BACTERIAL) PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily furosemide. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBCs are recommended; therapy should be discontinued if a persistently reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur during therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. Blood dyscrasias: Agranulocytosis, aplastic anemia, hemolytic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, prothrombinemia and methemoglobinemia. Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, sunburn, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pain, hepatitis, diarrhea and pancreatitis. CNS reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, gait, muscle weakness and nervousness. Miscellaneous reactions: Drug fever, chills, acute nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some gollitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of gollit reduction, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Usage: Not recommended for infants less than two months of age.

Urinary Tract Infections and Shigellosis in Adults and Children, and Acute Otitis Media in Children:

Dosage: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

Patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

Acute Exacerbations of Chronic Bronchitis in Adults:

Dosage: Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

Pneumocystis Carinii Pneumonia:

Dosage: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supply: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. Pediatric suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), cherry-flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 80 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

Heart attack or stroke could make the best years of your life the worst.



You have loved ones, a future, good health. It could all be lost with a heart attack or stroke. And that happens. Last year, nearly one million Americans died of heart disease and stroke. And 200,000 of them died before retirement age.

The American Heart Association is fighting to reduce early death and disability from heart disease and stroke with research, professional and public education, and community service programs.

But more needs to be done.

You can help us support research and education by sending your dollars today to your local Heart Association, listed in your telephone directory.

Put your money where your Heart is.



American Heart Association

WE'RE FIGHTING FOR YOUR LIFE

Featuring: Medical Society Challenges Physician-Owned Company

MEDICAL SOCIETY CHALLENGES PHYSICIAN-OWNED COMPANY

The Suffolk County Medical Society is reported to have filed an advisory with the State of New York Insurance Department challenging the 71 percent increase in malpractice liability insurance premiums requested by the physician-owned Medical Liability Mutual Insurance Company (MLMIC).

The August issue of *Malpractice Lifeline* reports that in news releases issued following the filing, physicians from the Suffolk County Medical Society indicated that their separate actuarial studies and analysis "indicate that the premium increase should be no more than five percent, and if the collateral source bill recently signed by the Governor is taken into account, there is substantial evidence for a rebate in premiums . . ."

The Suffolk County physicians also took exception to the fact that MLMIC earned only 8.4 percent on investments last year.

"Such figures strain credulity in view of the current money market rates and the U.S. government securities earning 15 percent," said Frank R. Collier, M.D., Suffolk County President. The society's members also questioned MLMIC's "vast purchases of tax-exempt securities as well as long-term securities," expressing the view that "for every one percent increase in investment income, there is a 10 to 12 percent decrease in premiums."

A letter to the Deputy Insurance Superintendent of New York stated that the physicians had discovered "what appears to be a significant misrepresentation in MLMIC's rate request." The physicians allege that MLMIC is "in a healthy financial condition based on its current level of assets and reserves and that MLMIC could increase its reserves significantly without adversely affecting its financial strength."

An attorney for the county society stated that the advisory filing "raises serious questions about the need for any increase in malpractice premiums" in the state.

DPLC Editor's Note: As of May 1981 MLMIC had \$50,400,000 in capital and surplus and \$661,000,000 in assets.

AUTHOR SUGGESTS STAFF PHYSICIANS, NOT HOSPITALS, SHOULD ASSUME LIABILITY

According to James B. Cohoon, author of an article in the August issue of *Health Care*, when a hospital patient is injured by a negligent physician, the aggrieved plaintiff should proceed with legal action against the physician, not the hospital.

According to the author, the doctrine of corporate hospital liability imposes at least three general duties on hospitals: "to supervise the medical care given to patients by staff physicians; to suspend the privileges, temporarily or permanently, of discovered incompetent physicians; and to use reasonable care to select only competent staff physicians in

the first instance." To accomplish these duties, hospital governing bodies delegate to medical staff committees the responsibility for processing and assessing credentials of hospital staff applicants and for the review, analysis, and evaluation of clinical performance.

Mr. Cohoon argues that hospital governing bodies normally do not review or study reports on each individual physician, but accept the recommendations of medical staff committees. The physicians who serve on these committees and whose practices bring them into frequent contact with offending physicians are more likely to notice instances of negligence than are members of the hospital administration and governing body. In fact, suggests the author, medical staff knowledge regarding physician negligence rarely is imparted to the hospital administration.

Mr. Cohoon, therefore, proposes that the logical alternative to the corporate negligence doctrine would be to hold liable those medical staff committee members who are responsible for the selection and supervision of the medical staff.

"Although it may be desirable to hold hospitals liable under the policy of maximum compensation to injured plaintiffs, common sense, logic, and the practicalities of modern hospital operation dictate that holding liable those physicians who have been delinquent in reporting known incompetent doctors is the best way to encourage and assure the quality medical care to which the public is entitled."

DPLC Editor's Note: This article entitled "Piercing the Doctrine of Corporate Hospital Liability" was reprinted in the *Specialty Law Digest Health Care*, August 1981, from the San Diego Law Review Association 1980. Mr. James B. Cohoon wrote this article while studying law at the University of San Diego and since has graduated. We might add that Mr. Cohoon's sentiments generally are not shared by physicians nor are they in any way endorsed by the Department of Professional Liability Control of the Medical Society of New Jersey.

DID YOU KNOW

. . . Malpractice insurance with deductibles may become more common now that St. Paul, the nation's largest medical liability carrier, offers it. Taking the deductible can mean savings of up to 25 percent on the basic \$100,000/300,000 liability coverage. If, for example, you would normally pay a premium of \$10,000, you'd save \$500 with the minimum

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

\$5,000 deductible, \$1,000 with the \$10,000 deductible, and \$2,500 with the \$25,000 deductible, the highest that St. Paul offers . . . *Medical Economics*, August 24, 1981

. . . In recent years The Hartford Insurance Company has been the sponsored Louisiana State Medical Society carrier, but displeasure over a proposed 12½ percent rate increase and some other aspects of company/society dealings apparently led MDs to favor establishment of their own program. Hartford later agreed to whittle down premium increases, pay a higher interest rate on Premium Credit Plan dollars, use only Louisiana-based claims data in calculating rates, and so on. However, LSMS representative Henry Jumonville III said physicians "felt that over the long haul it would be the best thing" to launch their own operation, particularly in view of the success of other doctor companies around the county . . . *Malpractice Lifeline*, August 31, 1981

. . . Connecticut physicians have shelved their plans to establish a doctor-owned professional liability insurance company in light of the emergence of a new competitor in the market. CNA Insurance Company will be competing with Aetna this fall for a share of the medical malpractice insurance business, according to Timothy Norbeck, state medical society executive director.

CNA's 1982 premiums will be 12 percent below present Aetna rates for the basic package. It was Aetna's 24 percent and 60 percent increases over the last two years that led physicians to lay plans for their own company. Although the medical society has completed most of the groundwork necessary to get a company up and running, including securing a state charter, the company is being put on indefinite hold. "With a competitive atmosphere, we figured it was best for us to have [the company] ready to go, but to put it on the shelf, until we need it in the future," Norbeck said. "Hopefully, we won't need it." . . . *Malpractice Lifeline*, August 31, 1981

STUDY PROFILES HIGHEST RISKS IN EMERGENCY CARE BY MDs

A study of almost 2,000 malpractice claims has given physicians a unique profile of risky situations in emergency rooms.

Four years of analyzing more than 1,800 claims filed with the Emergency Physicians' Trust (EPT) yielded a list of complaints most common in malpractice cases, how costly they are, and what factors may contribute to claims.

"Some people have risk management programs but they don't have the insurance data we do. We get cases from EPT and have access to emergency room charts. Our system is unique because it yields more of the intangible risks," said John T. Rogers, M.D., a Lakeland, Florida physician who coordinates data analysis with six other physicians involved in the program.

Dr. Rogers divides common risks into patient, physician and temporal factors that often show up in malpractice cases.

"Patient risk factors include repeat visitors, injured drunks, a child who comes in alone and several psychiatric situations," he said.

"Physicians more at risk have age, language, communication or documentation problems, he said. Although unable to name a specific age range," Dr. Rogers said, "We find that the average age of those involved in a suit is a bit younger than the average age (44.1 years) of American College of Emergency Physicians (ACEP) members."

Communication is one of the most important tools to

prevent suits. "Show me a person who's never been sued and I'll show you a physician with a black belt in communication," Dr. Rogers said. "There are four factors that make a good physician: availability, affordability, ability, and the willingness to communicate."

Even good physicians can get in trouble if they do not document facts, he added. "Write it down. If it's not on paper, you're dead. Have all the data down on the chart before the patient leaves the emergency room."

Temporal factors indicate risks of claims increase during shift changes, longer shifts (any shift over 12 hours is dangerous Dr. Rogers believes) and during busy times. "There not only is more volume to increase risks during busy times, but a physician may have a tendency to rush and the patient picks that up," Dr. Rogers said.

Data from EPT, an ACEP-endorsed trust that insures approximately 2,000 physicians, show that fractures are the most common injury involved in malpractice cases with 19 percent of total cases, but they rank fourth in pay-outs, accounting for 12 percent of costs. Wound complications rank second in frequency and cost. Abdominal conditions come in third in both categories.

"Cardiac cases account for only seven percent of cases, which puts them in fourth place, but they are tops in costs, taking 18 percent of total dollars paid," he said.

Dr. Rogers said that he expects the newest data to boost meningitis cases from sixth in frequency and cost to second or third in costs. Annual summaries seldom show this big a shift, mainly lower-ranked categories will move a notch.

In courses for emergency physicians, Dr. Rogers said he suggests many ways to avoid risks and improve patient care, including a basic tenet, "Practicing good medicine is the basis of risk management." . . . *American Medical News*, August 14, 1981

MEDICAL GROUP FOR SECOND OPINIONS

As an answer to the increasing number of patients seeking a second opinion prior to consenting to surgery, Mary Ellen Hecht, M.D., has formed The Hecht Group: Second Surgical Opinions.

Dr. Hecht who is assistant chief of orthopedic surgery and assistant clinical professor at Mt. Sinai Medical School in New York, realized that patients were unsure where to get second opinions, particularly in her medical specialty field. So in 1980, Dr. Hecht established a medical and dental group composed of surgeons from the various surgical specialties as a source for patients to receive second opinions.

Each physician in the group has a private surgical practice, and as a consultant with the group, agrees not to perform surgery on a Hecht Group patient or make referrals for surgery.

In *Nation's Business* (May 1981) Dr. Hecht states, "This is one important aspect that makes us unique. Patients know we're not looking to operate because that is not our function and surgeons know that we'll never steal their patients."

Physician members of the group were selected for their surgical ability as well as their ability to consider each patient's individual interests and for their ability to communicate in language easily understood by patients.

"For one thing," says Dr. Hecht, "I don't think there is any such thing as minor surgery. It's a term usually used to describe someone else's operation. Facing surgery is an anxiety-producing situation. Knowledge and understanding reduce anxiety and improve the chances of surgical success."

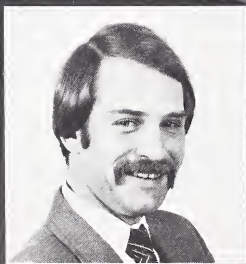
Larry Dlugolencki has become real friendly with medical assistant Fallon.

Larry is part of our special Blue Shield professional relations staff. Larry and his colleagues specialize in answering physicians' questions, and training their medical assistants.

You can depend on our professional relations staff for quick answers to your inquiries regarding claims, billing information, and contract interpretation.

In addition, professional relations staff members handle the enrollment of new participating physicians.

So, next time you run into a Blue Shield related problem, call on us for the answer.



*It's our job to
make things simple.*



Blue Shield
of New Jersey

The Physician in Today's Society

On August 15th, *The New York Times* published a letter to the editor written by a nurse. The tone of the letter is set by the statement, "Nurses and the administrator/physician today are on fundamentally different tacks. Nurses are expensive; illness is profitable." The implication is that hospital administrators and physicians are interested only in perpetuating illness while nurses are interested in restoring patients to health.

From the physician standpoint, this characterization of role seems both simplistic and untrue. After all, there are thousands of physicians whose lives are dedicated to finding new methods of combating disease both on a research and public health level and whose efforts have been notably successful. There are hundreds of thousands of clinicians who labor daily in their offices to maintain their patients in a reasonable state of health. Additionally, all of every physician's primary training is devoted to a single objective: development of the intellectual and manual skills necessary to diagnose and treat the various ills of mankind.

This is a very uncomplicated objective and one which the vast majority of physicians identify with prior to entry into medical school. It is also an objective which society itself has to consider as highly desirable, unless it wishes to engage in a self-destructive return to the era of widespread untreatable disease processes and pandemics of smallpox, malaria, and poliomyelitis.

Why, then, are physicians becoming the subject of hostile reaction from various groups in society at large as well as from some groups within the health field, as in this instance?

Without question, physicians are treating diseases more successfully than at any prior time in recorded history and society is incurring an increasing financial burden because of this success. Because the numbers of people living to an advanced age are increased, the Social Security program is imperiled. Because victims of cerebrovascular accidents are living in an impaired state for long periods of time, there is an increased demand for their care either in a nursing home or with their sons and daughters. Because there are many more treatment possibilities with expensive new technological advances, hospital treatment and health insurance have become much more expensive. Because there are more patients, and more patients who are critically ill, the demands on the various groups delivering care within a hospital are increasing while the numbers within these groups are dwindling, due to the efforts of hospital administrators to keep payroll costs down.

At the same time, physicians continue to treat people with disease as always and each such patient provides the physician with a fee for such treatment, with increasingly rare exceptions. In short, the perception from many viewpoints is that of a continuing enrichment of the physician, at the

expense of a great many elements of society.

This negative reaction is not directly the physician's fault, nor can it be blamed rightly on his success. It is simply another facet of the many sociological and technological revolutions that society as a whole is undergoing. However, physicians, as a profession, need to acknowledge that this negative reaction exists and that their own therapeutic efforts are contributing to it. In so doing, the profession puts itself in a position to formulate those aspects of this problem which lie within its powers to correct and those which require solution by either the private or political sectors of society as a whole.

For example, the public at large is convinced that a certain amount of unnecessary surgery and medical treatment is being performed—a part of the negative reaction. This perception is fostered by the media who report on practitioners caught filling out fraudulent claim forms or abusing the reimbursement system, and by particular sectors of the health field who rush into print with studies purporting scientifically to demonstrate the existence of unnecessary treatment in clinical practice. Such questionable conclusions are reinforced by the absence of any discernible effort on the part of the profession as a whole to provide accurate data refuting this sort of study or any discernible effort on the part of the profession to provide an oversight of the work of its individual members.

Clearly, what is required to eliminate this portion of the negative reaction is some group that will take the time and the trouble to accumulate an accurate data base accessible in aggregate to public inspection and which will issue a "seal of approval" regarding the medical necessity and reasonable quality of care of treatment rendered. Ideally, such a group should be composed of knowledgeable physicians, although any group of statisticians could establish such an organization.

Imagine the impact on the public if such a group were to come into true focus with the active support of the medical profession. Any claim of unnecessary surgery or other treatment could be refuted by both a concurrent certification of the patient treatment record and by comparison with the data base. Additionally, claims of physician abuse of the system would necessarily disappear since this kind of review would make such invidious practices very difficult to carry out. The surge in public confidence in the profession might even be great enough to cut down on malpractice claims.

There are those in the profession who feel that this sort of effort would represent an intrusion on their right to practice medicine without interference from anyone. Of course, the effort described above does not interfere with the practice of medicine, but it does represent "someone looking over your shoulder."

There are those in the profession who, in addition to rejecting such efforts, wish to be paid their usual and customary fee for treatment without any question by the third-party payer even if that payer happens to represent the taxpayers of this country.

As a matter of fact, the Medical Society of New Jersey has gone on record as against all forms of interference in the practice of medicine and for reimbursement at a usual and customary fee level for treatment rendered. Such an attitude

may well serve to accelerate the development of further negative reaction.

By contrast, acknowledgement of the developing negative attitude of society and acceptance of a willingness to provide a mechanism to establish medical professional accountability could be a significant step in reversing this trend.

In the words of a famous English statesman, "The price of freedom is responsibility for one's actions."

William A. Dwyer, Jr., M.D.

Anxiety and Action

When Ronald Reagan was elected President, it was on a platform of reduced spending, tax reductions and enhanced national security. Since health care is a huge portion of federal expenditure, it is not surprising that health programs were among the first to receive scrutiny with a view toward reducing costs. The resulting legislative activity not only was calculated to reduce expenditures, but at the same time has shifted the responsibility for implementing those reductions to the individual states. While we must applaud the intent, certain anxieties arise regarding the implications.

The most immediate anxiety reflects the general unpreparedness of state governments to deal with this added responsibility and burden. Medicaid support reductions and the use of the block grant concept for categorical health programs (funded at 75 percent of previous level) raises many fiscal and administrative problems which should be of concern to our profession. Tough decisions will have to be made and if made without input from the profession they will result in further erosion of our ability to provide quality and necessary care.

This is not to say the profession can or should escape the inevitable alterations in our practice that these economies will require. Two conclusions seem evident. First, it is essential that the profession assure its position in the de-

cision-making process by developing more extensive communication and influence on state health agencies—being sure health does not become subservient to or synonymous with welfare. Second, the profession must find a way to establish better health at lower cost by attacking those institutional and professional practices which perpetuate unjustifiable expense. Make no mistake, there is inefficiency in the health care system both at the administrative and delivery level. To achieve what we all know to be necessary will require some reordering of priorities and certainly a greater awareness of the magnitude of the problem.

Needs and costs of health care are bound to rise in a depressed economy. Economic recovery requires significant alterations in the way funds are utilized. Just as all sectors of our economy have contributed to the problems, so must all segments contribute to the solutions. None needs to be compromised in the process, but all need to develop priorities and restraints. Our profession faces mounting challenges as well as opportunities to demonstrate our leadership and dedication to our patient's interest. Each one of us has a role to play by being informed, concerned, and active. Find out from your medical society what you can do to help.

James S. Todd, M.D.
Trustee, American Medical Association

Medical
Collection
Law Firm

**For
Anesthesiologists
Radiologists
And Other Specialists
having problems with
Past Due Accounts**

Our law firm will administer to your collection matters promptly and expeditiously.

Fee: 25% of the amount recovered.

For more information call:

KAUFMAN, GARSHELL & SOLLER
(201) 677-9019

**NEW YORK
FERTILITY RESEARCH
FOUNDATION, INC.**

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

Are your dental bills taking
a bite out of your savings?

ANNOUNCING:
A Medical Society of New Jersey Sponsored
GROUP DENTAL INSURANCE PLAN

FEATURING:

- "Usual, Customary and Reasonable" (UCR) benefit payments that increase with inflation
- Only a \$25 deductible
- Orthodontia benefits
- PLUS all the advantages of a group insurance program

Look for your Group Dental Insurance Plan booklet and application in the mail
Administered by

DONALD F. SMITH & ASSOCIATES

A multi-line
insurance consulting
and brokerage firm

One Airport Place, Route 206 North, P.O. Box 2197, Princeton, New Jersey 08540 (609) 924-8700 (201) 622-6046
Underwritten by New Jersey Dental Service Plan, Inc.

CONTRIBUTIONS TO LEGISLATIVE CANDIDATES

The Candidate Evaluation Committee, chaired by Karl Franzoni, M.D., met in August to recommend JEMPAC contributions to candidates running for New Jersey's 120 state legislative seats. Drs. Harold Colburn, William E. Ryan, Robert Rigolosi, Frank Y. Watson and MSNJ lobbyists Edward Meara, III and Clark Martin offered information on each candidate as to his stand on issues, approachability and electability.

As a consequence, \$13,000 was recommended for distribution among thirty (30) Democratic and thirty-three (33) Republican candidates. The breakdown by Senate and Assembly is as follows: *Senate—40 seats:* Democrats—13, Republicans—11, total, 24 seats; *Assembly—80 seats:* Democrats—17, Republicans—22, total—39 seats. Decision on a half-dozen legislative districts that did not receive funding will be made when additional information is received.

Funds given to candidates come directly from the contributions realized through JEMPAC membership. JEMPAC has only 314 members and thus is limited in the amount it can contribute to candidates. During the last legislative election, JEMPAC ranked ninth among the largest PAC contributors with \$12,150. The Business PAC ranked first with \$58,500, the Dental PAC second with \$44,600, and the Lawyers' PAC fifth with \$33,975 in contributions.

GOVERNOR VETOES BILL OPPOSED BY BOARD OF TRUSTEES

At its April (1981) meeting, MSNJ's Board of Trustees took the position of **ACTIVE OPPOSITION** on *Senate Bill 251*. This bill, introduced by Senator Anthony Russo (20th District, part of Union), authorized the Division of Motor Vehicles to note on driver's license that licensee has diabetes. The Board of Trustees opposed the bill because it would "neither advance the health interests of patients with diabetes nor would it lead to any recognizable results in highway safety."

Later in the same month Governor Byrne vetoed *S-251*.

MSNJ's POSITION ON PROPOSED NJ LEGISLATION

Assembly 2308—Walter Kern (40th District, part of Bergen) To require Blue Shield contracts to include inpatient radiology services. **ACTIVE SUPPORT.** Assigned to:

Banking and Insurance Committee: James Bornheimer, Charles Mays, Michael Aduato, Thomas Gallo, Louis Kosco, Carl Orechio, and Frederic Remington.

Senate 3261—Matthew Feldman (37th District, part of Bergen) To amend the law pertaining to medical malpractice suits and require plaintiff to submit an expert affidavit to the court and defendant. **CONDITIONAL APPROVAL**, pending amendment of bill—Line #13 change words "board

licensure" to "specialty board certification." (If bill amended—Active Support). Assigned to:

Judiciary Committee: William Vincent Musto, John M. Skevin, William J. Hamilton, Jr., Joseph A. Maressa, Carmen A. Orechio, Steven P. Perskie, John F. Russo, Walter N. Sheil, James S. Cafiero, John H. Dorsey, S. Thomas Gagliano, James P. Vreeland, Jr.

LIMIT ON PAC AID PROPOSED IN HOUSE

The influence of association PACs could be threatened by a recently introduced House bill that limits the total amount of money a congressional candidate can collect from PACs. The bill, "Campaign Finance Reform Amendments of 1981," would not allow House candidates to collect more than \$75,000 from all PACs in each election. The limit for Senators would depend on the size of the state and would range from \$75,000 to \$500,000. Congressman Mike Synar (D-OK), one of the bill's sponsors, expresses concern over the large increase in PAC spending in recent years. "This shift from broad-based support of the organized political parties to the narrowly defined support of special interest groups can only fragment the political process," he says. (*Association Management, September 1981*)

SOUND FAMILIAR?

The following interesting quotes appear in an article from the April (1981) issue of the *Reporter*, entitled "Reflections of a Country Lawyer in the State House" by Daniel J. O'Hern, an Associate Justice of the New Jersey Supreme Court.

"The 'civil service required in present-day government has grown so large, both in numbers and annual cost, that it has become a major problem. I shall ask that the Legislature give consideration to such revision of the civil service laws which will make possible better administration and more economical service." *Governor Morgan F. Larson in 1920.*

"I now earnestly recommend to your favorable consideration the proposition to remove the State property tax entirely ... I see no reason to believe that it will ever again be necessary to impose a State tax ... [and] there is no probability of the recurrence of another fatal period of unnatural inflation during the lifetime of the present generation." *Robert E. Lee in 1879-1880.*

CALL YOUR CONGRESSMAN

For a free telephone directory of all members of the Senate and House of Representatives, contact the Clerk of the House, H-105, Capitol Building, Washington, DC 20515; phone (202) 225-7000.

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. FBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android[®] 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. / mg. / mg.

Methyltestosterone U.S.P. Tablets
A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



for "cardiac separation"...



Although over 80% of post-coronary patients can resume normal marital sexual activity, fear of anginal pain often results in "cardiac separation" between patients and their families.

You can help minimize "cardiac separation" with a program of

counseling and often, with a prescription for Cardilate® (erythrityl tetranitrate).

Cardilate® increases exercise tolerance, helps patients return to more normal levels of activity—including sexual activity. Sublingually, Cardilate begins to

work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to 2 hours.

counsel &
Cardilate®
(erythrityl tetranitrate)

CARDILATE® (ERYTHRITYL TETRANITRATE)

INDICATIONS: Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

CONTRAINDICATIONS: Idiosyncrasy to this drug.

WARNING: Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Intraocular pressure is increased; therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspira-

tion and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

DOSEAGE AND ADMINISTRATION

Oral/Sublingual Tablets. Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg. prior to each anticipated physical or emotional stress and bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED

CARDILATE (Erythrityl Tetranitrate) TABLETS (Scored)
for ORAL or SUBLINGUAL USE: 5 mg. Bottle of 100,
10 mg. Bottles of 100 and 1000. 15 mg. Bottle of 100.

Reference: 1. Hellerstein HK, Friedman EH. Sexual activity and the postcoronary patient. Arch Intern Med 125:987-1970.

Burroughs Wellcome Co.,
Research Triangle Park, North Carolina 27709



Patient's Rights: Where Are We? Where Are We Going?

RUSSELL L. McINTYRE, Th.D., Piscataway*

The concept of "patient's rights" is firmly established in the United States. Historical antecedents can be traced far back into Western religious and medical traditions. Recent legal and social movements have articulated and affirmed specific rights of patients and permanently have altered the landscape upon which medicine is practiced today.

WHERE HAVE WE COME FROM? THE RISE AND DEVELOPMENT OF PATIENT'S RIGHTS

The current development in defining the parameters of physician-patient relationship referred to as the "patient's rights movement" can be dated from 1972, the year in which the American Hospital Association published its now infamous "A Patient's Bill of Rights."¹ The historical antecedents, however, can be traced far back into Western religious and medical traditions. The Biblical "Golden Rule" requires that we "do unto others what we would want done to ourselves." The Hippocratic Oath amplifies this principle for the physician in the injunction to "do that which in his judgment is *best* for his patient." More dogmatic and stringent are the requirements set forth in the Law Code of Hammurabi (c.2000 BC), one of which requires, "if a physician shall cause the death of a patient, his hands shall be cut off."

American legal developments to define patient's rights began about the turn of this last century, most notably in the 1914 decision of Justice Cardozo in New York. "Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . ."² It was this decision that first established (in the United States) the patient's right to give "informed consent." The court continued, "and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages."

In the first of the modern cases (1960), a Kansas court declared that "a man is the master of his own body and he may expressly prohibit the performance of lifesaving surgery or other medical treatment. A doctor may well believe that

an operation or other form of medical treatment is desirable or necessary, but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception."³

Two more recent decisions articulate the patient's "right of privacy" and define limits to which the state can go in its mandate to "protect and preserve life." The first is the United States Supreme Court decision on abortion which gives a woman the right to determine—within the first two trimesters of pregnancy—whether or not she wishes to continue with the pregnancy or, legally, seek its termination.⁴ Only in the third trimester, when the fetus is potentially viable outside the womb, does the state have the right to restrict her personal freedom of choice and impose requirements against the termination, the only exception being whether or not the woman's health is threatened by the continuation of the pregnancy. The second "privacy" decision came from the Quinlan Court, which allowed for the patient's right of privacy to take precedence over the "state's interest in protecting and preserving life."⁵ The patient or her guardian may refuse life-preserving therapy when it is clear that the patient is near death and the condition is irreversible.

Equally as important as the legal developments are the tremendous social changes which have occurred in the United States in the past three decades. Indeed, a strong argument can be made for seeing that the changes in the legal

*Read before the Symposium on Medicine and Religion, 215th Annual Meeting of the Medical Society of New Jersey, May 16, 1981, Secaucus. Dr. McIntyre is Assistant Professor (Medical Ethics) and Chaplain, CMDNJ, Rutgers Medical School, Piscataway, NJ. He may be addressed there.

climate were generated because of the major changes in the social climate of American society. The "patient's rights movement" has emerged as a natural outgrowth of these social developments. At least four factors must be identified. First, the "civil rights" movements of the mid-1950s, which were intensified in the 1960s, represented the struggle of minority citizens against discriminatory social practices. Second, the rise of "consumerism" in the early 1970s, represented the struggle of the masses against widespread exploitative economic practices. Third, the "malpractice crisis" of the 1970s represented the opportunity of the consumer of health care services against the perceived—or real—inadequate, incomplete or insensitive care of the "professional" classes, including physicians, dentists, psychologists, nurses, lawyers and others, including clergymen. Finally, the "women's movement" which represented the struggle of a self-identified "minority" against discriminatory hiring and compensation practices and the demand for equal access to the benefits of the American dream. All of these movements have coalesced to articulate specific rights of patients (citizens) and specific obligations for the health-care professional.

WHERE ARE WE?

The "Patient's Bill of Rights" of the American Hospital Association, which can be identified as the foundational document of the movement, does not stand alone. Indeed, documents describing the patient's rights developed just in the past ten years represent a movement from paucity to plethora—from too few to an overabundance.

Codes of medical ethics or codes of professional responsibility have two purposes: first, to identify practices that were in existence at the time the codes were written which the profession wanted to label as unethical or inappropriate for the professional person; and, second, to facilitate a climate of trust and respect in which that profession can practice to the maximum benefit of all parties, i.e., patient and physician.

The Hippocratic Oath is a sterling example of this; most physicians as well as most lay people would acknowledge that this is true. Patients want to have confidence in you and trust that you always will have their best interests at heart.

Some brief examples of this include the following: (1) the Hippocratic Oath rejects the public display of patient care—very common in its day—and holds up the ideal of confidentiality and the obligation of the physician to respect the privacy of the patient; (2) the first code of Medical Ethics written by the American Medical Association (1847) rejects "ghost surgery" and "fee splitting" as unethical behaviors for physicians and holds up a standard of honesty in the physician's dealings with his patients; (3) the 1947 Nuremberg Code of Medical Ethics rejects the indiscriminate use of human subjects for medical experimentation and holds up the ideal of informed consent with the patient's right to withdraw from the research protocol at any time without prejudice toward future treatment.

The "Patient's Bill of Rights" of the American Hospital Association states very specifically that the patient has:

- (1) the right to considerate and respectful care;
- (2) the right to obtain from his physician complete and current information concerning his diagnosis, treatment and prognosis—in terms that he can understand;
- (3) the right to give informed consent prior to the start of any procedure and/or treatment;
- (4) the right to refuse treatment to the extent permitted

by law, and to be informed of the medical consequences of his action;

- (5) the right to privacy;
- (6) the right to confidentiality;
- (7) the right to expect that, within its capacity, the hospital must make reasonable response to the request of a patient for services;
- (8) the right to know if there is any professional relationship among professionals, by name, who are treating him;
- (9) the right to know if any part of his treatment or care is experimental;
- (10) the right to expect reasonable continuity of care;
- (11) the right to examine and receive an explanation of his bill regardless of source of payment; and, finally,
- (12) the right to know what hospital rules and regulations apply to his conduct as a patient.

WHERE ARE WE GOING?

Kenneth Boulding, an eminent British economist and social historian, has commented on the impact of modern technology on life as follows: "there is no historical model on which to build the society of the future." As phenomenal as the changes in the technologies of medicine have been, equally dramatic have been the changes in the context in which medicine is practiced.

Especially in America, with its distinctive social values, the issue of "patient's rights" has changed the very landscape of medical practice. The AMA, I believe, has decisively recognized this in its most recent formulation of the "Principles of Medical Ethics" adopted in 1980.

The Preamble of that document states that "the medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient." The document then identifies seven major principles which "are not laws, but standards of conduct which define the essentials of honorable behavior for the physician."

What we must note is that each of the statements regarding the physician's responsibility becomes a statement of "patient's rights." For example, the new code begins:

- (1) "A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity." Translated into "A Code of Patient's Rights," this becomes: "A patient has the right to expect that his physician shall be dedicated to providing competent medical service with compassion and respect for his human dignity."
- (2) "A physician shall uphold the honor of the profession by dealing honestly with patients and colleagues and striving to expose those physicians deficient in character, competence, or who engage in fraud or deception." This principle, as a statement of "patient's rights," becomes: "A patient has the right to expect that his physician will deal honestly with him and will strive to expose those physicians deficient in character, competence, or who engage in fraud or deception."
- (3) "A physician shall respect the law, and also recognize a responsibility to seek changes in those requirements contrary to the best interests of the patient." This statement becomes: "A patient has the right to expect that his physician shall respect the law, and also recognize a responsibility to seek changes in those requirements contrary to the best interests of the patient."
- (4) "A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall

safeguard patient confidences within the constraints of law." For the patient's "Code" this becomes: "The patient has a right to expect that the physician shall respect the rights of patients . . . and shall safeguard patient confidences within the constraints of law."

Each of the seven principles of the new AMA Code translates to a patient-right or a patient-expectation. To affirm a responsibility on the part of the professional is to identify a right or expectation for the patient. There is, of course, a major problem with patient's rights. Patients are not as technically trained as physicians; they are not as knowledgeable and experienced and, left to their own devices—or with the right to veto what the physician recommends—they can, and often do, make wrong decisions or bad choices.

Six rather clear clinical examples of this are identified by Jackson and Younger.⁸ The authors argue that "superficial and automatic acquiescence to the concept of patient autonomy and death with dignity threatens sound clinical judgment as physicians." They continue "we strongly support the principles of patient autonomy and death with dignity and welcome any dialogue that promotes them." However, "we must continue to emphasize our professional responsibility for thorough clinical investigation and the exercise of sound judgment. Living up to this responsibility," they conclude, "can only enhance the true autonomy and dignity of our patients."

CONCLUSION

The concept of "patient's rights" is firmly established in the United States. It is recognized pervasively in both case law as well as in documents describing professional responsibility in medical and health care. The movement of "patient's rights" and other coalescing social movements have altered the landscape of medical practice and led to the development of specific responsibilities for physicians. The impact of the movement is not likely to diminish in the 1980s.

The pervasiveness of the "patient's rights movement" is demonstrated not only in the official—or adopted—documents of the American Medical Association or the American Hospital Association, but in the common press, i.e., what the average lay person reads and believes to be true regarding his or her rights. An example of this is found in one of the popular newspaper columns by Ann Landers.⁹ The column was entitled "The Rights of the Dying" and although it is not a legal document, it expresses very succinctly what a growing number of lay people feel about their rights and, of course, the responsibilities of those providing their care.

THE DYING PERSON'S BILL OF RIGHTS

I have the right to be treated as a living human being until I die.

I have the right to maintain a sense of hopefulness, however changing its focus may be.

I have the right to be cared for by those who can maintain a sense of hopefulness, however changing this might be.

I have the right to express my feelings and emotions about my approaching death, in my own way.

I have the right to participate in decisions concerning my care.

I have the right to expect continuing medical and nursing attention even though "cure" goals must be changed to "comfort" goals.

I have the right not to die alone.

I have the right to be free from pain.

I have the right to have my questions answered honestly.

I have the right not to be deceived.

I have the right to have help from and for my family accepting my death.

I have the right to die in peace and dignity.

I have the right to retain my individuality and not be judged for my decision, which may be contrary to the beliefs of others.

I have the right to discuss and enlarge my religious and/or spiritual experiences, regardless of what they may mean to others.

I have the right to expect that the sanctity of the human body will be respected after death.

I have the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death.⁹

REFERENCES

1. American Hospital Association: *A Patient's Bill of Rights*. Chicago, AHA, 1972.
2. Scholendorf vs. Society of New York Hospital (105 NE 92, 1914).
3. Nathanson vs. Kline (350 P 2d 1093, Kans 1960).
4. Roe vs. Wade (410 US 113, 93 S Ct 705, 1973).
5. In the Matter of Karen Ann Quinlan (70 NJ 10, 355 A 2d 647, 1976).
6. Toffler Alvin: *Future Shock*. New York, Bantam Books, 1970.
7. American Medical Association: *Principles of Medical Ethics*. Chicago, AMA, 1980.
8. Jackson DL and Younger S: Patient autonomy and death with dignity: Some clinical caveats. *N Engl J Med* 301: 404ff, 1979.
9. Landers Ann: The Rights of the Dying. Nationally Syndicated Column, September 28, 1978. Quotation of *The Dying Person's Bill of Rights* is from the Southwestern Michigan In-Service Education Council.

Euthanasia: Where Are We? Where Are We Going?

MARVIN S. FISH, Newark*

"Life or Death—Whose Decision?"; "Who Shall Live When Not All Can Live?"; patients referred to as "unproductive," "unemployable" or "socially incompetent"; "cost-effectiveness"; "scarcity of resources"; "avoidance of prolonged suffering." These titles and considerations reflect a willingness to interfere with the natural dying process. Lawyers, ethicists, physicians and the public are accepting, fostering and expanding this. Where is it going?

The word "euthanasia" is derived from two Greek words which essentially translate into "easy death." But the questions are: (1) Easy for whom? (2) How do you define "easy"? If keeping one alive is difficult (as to time, price, effort, strain on others) then death may be considered "easier"; isn't that true?

Active euthanasia is direct action which terminates the life of a person who is suffering and who is irreversibly close to death. Passive euthanasia either may be a failure to use a particular available modality of treatment or not commencing treatment which is apparently essential in order to sustain life. If a patient asks for either of these, it is considered to be voluntary. If the patient does not ask for either, then it is considered to be involuntary.

The issue is whether or not the patient is able to ask. If the patient is able to make the request and the choice is to die, the current trend of thinking is to allow it. If the patient's request is to continue to be sustained, the general feelings are that this should be honored. However, I know of no writer who has spoken on the issues of the interests of others and the cost and availability of resources for such a patient who insists, but for whom the hope of reversing the terminable condition is nil.

If the patient is unable to make a decision, then we must face the main issue. An attempt may be made to determine what the patient would have wanted. This is called "substituted judgment." If this can be done effectively, we are

back to the original proposition where the patient's request has been made known. But, assuming that you cannot determine what the patient would have wanted if the patient had been able to express himself or herself and assuming that there is no "Living Will," then what do we do? Here, I submit, is the focal point of our attention: the quality of life concept. This is where we are.

The various people in this situation have different roles and problems. The physician is dedicated to protect, preserve and promote life, to do no harm, and to alleviate suffering. The problem arises when these responsibilities conflict with the perceived needs and interests of persons other than the particular patient.

WHERE ARE WE?

Clother speaks of two distinctly different types of patients.¹ The first is one who has been suffering from intractable pain associated with an incurable disease. Here the duty of the physician is to ease the pain and to prolong life. If the patient is competent and desires to terminate his life, most writers agree that this should be permitted. The other type of patient is one who has been reduced to a permanent vegetative existence as a result of irreversible brain damage. This is the comatose and obviously incompetent patient. In such

*Read before the Symposium on Medicine and Religion, 215th Annual Meeting, MSNJ, May 16, 1981, Secaucus. Mr. Fish is a member of the firm, Slavitt, Fish and Cowen, Counselors at Law. He may be addressed at 17 Academy Street, Newark, NJ 07102.

instances, the issue of quality of life and euthanasia will apply.

The definitions of words such as active, passive, voluntary, involuntary, withholding, terminating, mandatory, permissive, ordinary and extraordinary can be found in a paper by Kaplan.² Questions were raised such as who might qualify for euthanasia, what would be appropriate for consent, vicarious consent, revocation of consent, immunity from liability and penalties for abuse. The roles of the legislatures and the courts were considered and an ultimate proposal for a model act was presented.

Childress dealt with conflict situations, criteria of selection and proposals such as "random choice" and "first come, first served." He proposed the formation of a lay committee whose functions would be to determine whether a particular patient might be so indispensable that he should be saved, even if it means sacrificing the values of a particular selection process.³

Jaretzki presented a guide to physicians who deal with dying patients.⁴ Among the considerations presented were the wishes of the patient, the age, responsibilities and anticipated quality of life for the patient, the mental and physical state of the patient prior to the present illness, whether all reasonable treatments already have been employed and the financial resources of the patient and family.

An issue presented by Leon R. Kass was: "When, if ever, is it appropriate to withhold or interrupt treatments that might be life preserving or life prolonging?" Dr. Kass succinctly states several issues and concludes that the concern of the physician should be the condition of the life to be sustained and not especially its duration.⁵

Bayles took the position that life itself is not intrinsically valuable but that it is the quality of conscious life which is important.⁶ If the patient is a competent adult, the decision is entirely that of the patient. Then the issue turns to the allocation of limited resources and the cost to others for fulfilling the desires of that particular patient. If the patient is not a competent adult, the test is different. Here, the author states that "Life is no longer of value if most reasonable people would judge that it is not."⁶

On March 31, 1981 the Court of Appeals of the State of New York, the highest court of that jurisdiction, rendered a decision which held that where there is no reasonable chance of recovery, doctors legally may stop administering "extraordinary" medical care to terminally ill and incompetent patients who previously "clearly and convincingly" have expressed opposition to being kept alive artificially. But the issues of "reasonable chance of recovery" and the scope of "extraordinary medical care" need to be decided by a court if there is any question as to their definitions or applicability. Our purpose is not to analyze or criticize that court decision, but just to acknowledge the fact that this is clearly a change. We now see that the older mores of continuing to treat,

"... the concern of the physician should be the condition of the life to be sustained and not especially its duration."

regardless of the situation, are being reexamined and redefined.

The Supreme Judicial Court of Massachusetts, in the famous *Saikewicz* decision, dealt with a legally incompetent patient who was terminally ill and for whom there was a possibility of providing life-prolonging treatment. The Court said the decision was to be made by the Probate Court which should apply the subjective test of "substituted judgment," which is an attempt to find out how the patient, if legally competent, would have decided the issue. The end result was that the patient was not treated when the Court knew that such treatment clearly would have prolonged the life of the patient but the quality of life would have been poor due to adverse side effects, discomfort, fear, pain and a limited prospect of benefit. The Court dealt with a constitutional principle of right of privacy and ostensibly tried to determine what would be in the best interests of the incompetent but wrote it all off when it faced a patient with an I.Q. of 10. When the Court was asked to face the issue of "quality of life," it rejected the principle by stating that the value of life under law has no relation to intelligence or social position. The same court in the famous *Dinnerstein* decision dealt with a patient who was in the terminal stages of an "unremitting incurable mortal illness" and said that for such a patient the approval of the Court was not necessary in order to have a "do not resuscitate" order. The Court said this was a case entirely within the competence of the medical profession. The question was what measures are appropriate in order to ease the imminent passing of an irreversibly, terminally ill patient in light of her history and family wishes. Such a decision clearly could be made by the physician.

The same court then heard the case of *In the Matter of Spring*, 399 N.E. 2d 493 (Mass. App. Ct., Dec. 21, 1979). This was a case of a man who retired at the age of 65. When he became 77, he went into kidney failure and began dialysis treatments. He began to show signs of mental disorientation, his behavior became somewhat belligerent and destructive and he could not care for himself. A psychiatrist diagnosed his condition as chronic organic brain syndrome; within a year he was no longer able to recognize his wife and son. However, he was not officially declared incompetent. His wife and son petitioned the Court to stop the hemodialysis. The Court allowed the termination of the treatment with two main tests. The first was an attempt to determine what the patient would have wanted for himself which is the "substituted judgment" rule. The other was an evaluation of the State's general interest in the preservation of life. In this case the Court said that such general interest was not sufficient to warrant intervention in the treatment decision. And so we see the balancing of the patient's desire as against the public interest. What is that interest now? What might it be tomorrow?

"... where there is no reasonable chance of recovery, doctors ... may stop administering 'extraordinary' medical care to terminally ill ... patients who previously have ... expressed opposition to being kept alive artificially."

WHERE ARE WE GOING?

The AMA House of Delegates, in December, 1973, made certain recommendations contained in the report of the Judicial Council.⁷ One recommendation was that the physician should respect the expression of the wishes of the patient but should feel free to question those wishes with the participation of the patient's legal representative or by appropriate judicial proceedings. This implies that the patient wants to die. But suppose the patient wants to live and has expressed this. Does the patient have the absolute right to insist upon extraordinary care? Will patients always have the right? What about the interests of other patients, members of the family, economic considerations, scarcity of resources and the view of someone else as to the quality of the life?

McCormick defined "meaningful life" and used words like "hopelessly ill," "irretrievably in the dying process," and "wretched, painful or deformed condition"; in so doing, he begins to condition the mind of the reader.⁸ In discussing a topic called "Are Guidelines Possible?", he speaks of the issue of who will make the decision, and moves rapidly into criteria, basing all of this on the reality of the sophistication of modern medicine. The ultimate conclusion is "Since we have the power, we must face the responsibility."⁸ This author was dealing with neonates and was concerned with potentials for human relationships. The inference was that if the potential was substantially low, less effort should be expended in an attempt to save such a life from almost certain termination. If these principles can be applied to problems at the beginning of life, why should the same principles not be applicable when the patient is much older and closer to what might be considered a more natural time of death?

The problem of a choice between life and death, and more particularly who will make such a choice, was addressed by Williamson.⁹ After stating the problem, Williamson faced the issue and suggested that "... the team approach of physician and clergy working together, with patient and family, is the ideal solution to this problem."⁹ Whether or not the problem is stated correctly or this solution is best, we clearly are ready to deal with it.

Norman L. Cantor, Professor of Law at Rutgers Law School in Newark, N.J., has written about the *Quinlan* decision.¹⁰ He acknowledged the fact that the New Jersey Supreme Court had shifted away from the substituted judgment test and had moved toward the facts of the particular case. This author, as well as others, concludes that we clearly have injected the concept of "quality of life" as a major consideration in handling this type of patient.

In 1979 the New Jersey Supreme Court rendered an opinion known as *Berman vs. Allan* which involved a mother in her late 30's who was not advised about the availability of amniocentesis. She claimed that if she had known the probability of the outcome, she would have requested an abortion. The claim was in behalf of the child and for the parents for the emotional distress. The claim of the child was dismissed but the rights of the parent to claim damages for their emotional upset was preserved. Does this not recognize the growing right on the part of one person to choose the quality of life of another? Or is the fetus and then the neonate something different from a patient at some other age and stage of life?

The Delaware Supreme Court on September 23, 1980 in the case of *Severns vs. Wilmington Medical Center, Inc.* stated

that the Court had inherent power to appoint a comatose patient's husband as her guardian knowing that the request was an order to terminate life-support systems "if the evidence warranted it." The Court said that a hearing should be held at the request of the husband after which the Court could and would make a decision. Again, allowable intentional voluntary termination becomes a possibility.

The American Medical Association's Judicial Council published three recent opinions.¹¹ One stated that "priority should be given to persons who are most likely to be treated successfully or have long-term benefit. Social worth is not appropriate criterion." As to treating terminally ill, incompetent patients, the Council stated, "The physician should consider what the possibility is for extending life under humane and comfortable conditions and what are the wishes and attitudes of the family or those who have responsibility for the custody of the patient. Where a terminally ill patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis, all means of life support may be discontinued." Although the Council speaks against "social worth," how would you characterize words like "severely defective," "humane and comfortable conditions" and "wishes and attitudes of the family?"

The *New York Times* recently published a feature article entitled "Determining When Life Begins and Abortion Stops."¹² The article deals with the movement on Capitol Hill to resolve the issue and to determine the moment when life begins. If life is determined to begin at the moment of conception, then the fetus will be deemed a "person" under constitutional law and those who participate in aborting the life of that person could be prevented from doing so regardless of the prospective condition of the child. If, however, our legislature decides that life does not begin at that moment, but at some time thereafter, another issue arises. If we can scientifically evaluate the quality of the outcome of conception, and if someone has the right to terminate the pregnancy before birth because of a qualitative deficiency in the mind of the actor (whether that be parent, physician, court, committee or otherwise), then might not the same principle apply after birth?

QUERY

If you may terminate care for the unconscious patient who has an unlikely prospect of a return to a cognitive state, why then may you not provide a lesser quality of care (or perhaps even terminate all care) for the patient who is conscious but "so insane" as not to be cognitive? Why does one situation cause a reaction of "moral outrage" when the other does not? Isn't this another example of a relationship between quality of life and quality of care which the law will require?

CONCLUSION

McIntyre made some suggestions which should be considered.¹³ He suggested that "... the continuation of biological life is not the ultimate end value. We must not sacrifice life as long as there is reasonable hope and we certainly must not sacrifice hope when there is reasonable life. But, both hope and life have reasonable limits which the rubric of care recognizes." He suggests that one of our difficulties is the "false separation of human values regarding life and death" and that "... most of us only have values of life and have not thought very much about values of death, whether it be our own death or someone else's." Being

dedicated "to the care of souls as well as the care of bodies," we need to recognize also the existence of what he calls "terminal therapy" rather than euthanasia. He sees the general proposition of being dedicated to providing life-sustaining therapies in the care of all persons, but also the exception for those persons who are "terminally ill and irretrievably comatose or in intractable pain." It is with this principle as well as that exception that I concur.

The definition of the terminology being used in these situations and the identity of those who will define and apply that terminology is about to become a reality through our legislature or through our judiciary. There is yet time to participate in those determinations. If we fail to do so, we should not be heard to complain either about the effect upon us as providers or, indeed and for certain, as patients.

REFERENCES

1. Clothier F: *Euthanasia—The physician's dilemma* (A pamphlet). New York: Concern for Dying. November 19, 1972.

2. Kaplan RP: Euthanasia legislation: A survey and a model act: *Am J Law and Med*, Vol 2, 1976.

3. Childress JF: Who shall live when not all can live? *Soundings*, 43:353, 1970.

4. Jaretski A: Death with dignity—passive euthanasia. *NY State J Med*, 76:539 (Apr) 1976.

5. Kass LR: Ethical dilemmas in the care of the ill: II. What is the patient's good? *JAMA* 244:1946, (Oct) 1980.

6. Bayles M: The value of life by what standards? *Am J Nursing*: 2226, (Dec.) 1980.

7. The physician and the dying patient report of the Judicial Council, AMA to the AMA House of Delegates, December, 1973.

8. McCormick R: To save or let die—The dilemma of modern medicine. *JAMA* 229: 172-176, 1974.

9. Williamson W: Life or death—Whose decision? *JAMA* 197:139, 1966.

10. Cantor: Quinlan, privacy and the handling of incompetent dying patients. *Rutgers Law Review* 30: 243, 1976.

11. AMA Insights. *JAMA* 245:819, 1981.

12. *The New York Times*, Thursday, April 23, 1981, pg. B9.

13. McIntyre R: Euthanasia: A soft paradigm for medical ethics. (A leaflet) 1977.

Medical Ethics: Where Are We? Where Are We Going?

JAMES S. TODD, M.D., Ridgewood*

Medical ethics, which "are designed to help doctors make the right choices in the moral problems that confront them and their patients," are changing. They reflect the complexities of modern society. The physicians' ethical responsibilities are discussed.

It would be too simple I suppose to answer the question "Medical Ethics, where are we and where are we going?" by saying "In a mess, and God only knows!" Certainly, if nothing else we are living in interesting times. Times where scientists study less our origins and more what our finish is to be. Times where government intervention makes it possible for us to have diseases we couldn't otherwise afford, and times where Tom Lehrer's refrain "I'll meet you after the war, about thirty minutes from now" seems not impossible. All around us there seems to be a crisis in medical creditability. Cost is attacked, care is said to be unavailable, methods of treatment that sometimes border on quackery and a slowness of the profession to change to what the public perceives to be necessary are assailed. At the bottom of all of this has to be the ethical stance of the profession from which all else should be expected to flow.

The history of medical ethics is somewhat spotted and jaded. The Hippocratic oath has not really stood the test of time, for if it had we all would be swearing by the god Apollo, and there would be no surgeons since surgery was proscribed. For years ethical pronouncements were more those of a guild or craft code of conduct, blatantly more for the practitioners' benefit than for that of the patients.

Slowly, though the trend has been toward rights and responsibilities. Medical ethics are complicated by intent and by syntax. Are they to be prohibitions, or ideals worthy of aspiration? Whom are they for? The physician or the patient

or society? How are they generated? Who enforces them?

During the deliberations of the Ad Hoc Committee on Medical Ethics of the American Medical Association, the committee concluded that: (1) morals are those general principles of behavior which apply to all segments of society, and (2) ethics are a particular application of these general rules to a specific segment of that society. Therefore, there is no specific code of ethics for the medical profession, only a particular application of these more general principles setting the limit beyond which behavior is unacceptable. As morals change, and they do, so must ethics. Ethics evolve out of human experience, telling one what ought to be done, and defining the essentials of honorable behavior. Unfortunately, they are not precise. They are open to interpretation and, of course, misunderstanding. There are great problems when considering changes in ethics; many consider them to be immutable, handed down from on high, not to be changed and standing as rules for all time. Clearly, there is a relationship of ethics to law, but in many instances ethics may well be more demanding than the law. Of course, there is the dispute of situational ethics versus consequential

*Read before the Symposium on Medicine and Religion, 215th Annual Meeting of the Medical Society of New Jersey, May 16, 1981, Secaucus. Dr. Todd is a member of the Board of Trustees of the American Medical Association and immediate past-chairman of the Board of Trustees of the Medical Society of New Jersey. Correspondence may be addressed to him at 130 Prospect Street, Ridgewood, NJ 07450.

"Morals are general principles of behavior which apply to all segments of society; ethics are application of these rules to a specific segment of that society."

"Medical ethics are designed to help doctors make the right choices in the moral problems that confront them and their patients."

ethics, and more recently the promise-keeping type of ethics versus the covenant making with society.

Despite all of this discussion, however, reduced to its barest terms, the public is entitled to two things from physicians: competence and the expectation that physicians are acting in the patient's best interest, and who shall determine it? As a result of the technological explosion both competence and the patient's best interest are increasingly difficult of definition. There is a problem of the allocation of scarce resources, therapeutic choices are greater and decisions more difficult. Where is the role of do-not-resuscitate orders? What is the appropriate use of intensive care units versus routine care settings.

Conventional ethics and morals traditionally largely deal with one-to-one situations, and are established for individual guidance, yet society is increasingly becoming interested in individual decisions. Medical ethics are designed to help doctors make the right choices in the moral problems that confront them and their patients. But also, to some degree they should indicate what the public can expect from the profession. Yet it would be naive to rely exclusively on a sense of virtue to regulate the actions of professionals.

In the last several years, the public perception of the medical profession has changed radically. This crisis in confidence may be a consequence of medical specialization and the attendant diminution of the personal nature of relationships between doctors and patients, a public realization of the fallibility of physicians, a mistrust for all authority and established institutions or a disbelief in the profession's own honesty in admitting the tentativeness of some of its practices. Whatever its causes, though, the increasing unwillingness of patients to accept uncritically the health care determinations of physicians is demonstrated by the growth of informed consent, malpractice suits, development of second opinions, and finally a real interest in non-conventional health care.

Both society and the courts are challenging the role of the medical profession. The profession is no longer perceived as the sole guardian of the public health; there are limited-licensed practitioners and other nontraditional health care which the public increasingly seeks, and which more and more are protected by legislation and judicial fiat. More and more the public wants to get into the ethical decision-making process. Witness the rapid increase in interest in living wills, death with dignity, and prognosis committees. Court decisions such as Quinlan, Saikowitz and others regarding no codes are becoming increasingly frequent. Unfortunately, the record of the profession in the treatment of the untreatables is not too good, and the old adage of sustain life at all cost is now being questioned not so much by the profession as by the public. The result is that it is now harder to die with dignity, than it was before everyone started talking about it.

Lawyers are now appalled that physicians for centuries have been making decisions that the attorneys believe belong in the due process proceedings. Whistle blowers, who really don't understand the process, make physicians more reluctant to make the tough decisions for fear of personal or legal reprisal. All of this diminishes the stature of a physician and his ability to make reasoned moral and ethical decisions for and with his patients. For example, the precise moment that a fetus becomes a human being, or a comatose old man loses his personality cannot be demonstrated by logic nor determined by experiment. These views are religious in origin, and are not soluble by argument or political compromise. What seems to be happening is a substitution of uncertain regulation for that still small voice within. Indeed, ethics, especially bio-ethics, is a flourishing activity, and there is an ominous tendency to turn ethical principles into regulation. Kass,^a wrote "There is the notion abroad that there is, or that there can be and should be, a science of medical right and wrong, or at least, a proper decision making to which physicians can turn for expert help to solve medicine's ethical dilemmas. This is worse than an illusion. It represents a declaration of moral bankruptcy on the part of the profession, which once understood the ethical as integral to the medical, and which never supposed that the dilemmas of caring for the ill ever could be neatly solved. The call for rules, guidelines, and procedures, the convening of ethics committees, and the encouragement of statutory regulations are a search for yet one more technical solution—this time a technical ethical solution—for problems produced by our already foolish tendency to seek technical medical solutions for the weighty difficulties of human life. If a doctor would be a physician and not merely a body technician, he must also be a knower of souls, those of his patients and, not least, his own."

Well, despite this vain search on the part of some for simple, reproducible solutions, it should be recognized that all around us things are changing, and there must be some accommodation to that change. Quite clearly, subtle but significant things are happening in medical ethics. The trend is away from rules, regulations, etiquette, toward rights and responsibilities, promises and covenants and public participation in the shaping of principles. As this occurs, we as physicians must not be too distraught at the loss of tradition, but remember the distinction between a profession and a function. The function of health care is eternal, but the profession is temporal and can be destroyed or destroy itself quickly depending upon its response to the pressures upon it. We are going to have to realize the profession does not exist for itself, but for a purpose. Increasingly that purpose is

^aKass LR: Ethical dilemmas in the care of the ill. *JAMA* 244: 1946-1949, 1980.

going to be defined by those who commission our work, that is, the public and our patients. The present principles of medical ethics adopted by the American Medical Association in 1980 go a long way toward that recognition, emphasizing honesty, rights, responsibilities, speaking for the profession and defining *what* the public may expect from it.

But this may be not enough. Increasingly, it seems, ethical considerations are going to be a more conscious part of our daily experience. They will require active rather than passive consideration. Hopefully, this will occur as a benefit for the public, and not just to dissipate the zeal of the intervenors on crusades for vested interest, and I need not elaborate on that!

Where, then, are we going in medical ethics? Hopefully we are moving toward a more introspective, personal awareness of the magnitudes of the problems presented by an evermore complex technology and society. But as we do this, we must

"... ethical considerations are going to be a more conscious part of our daily experience."

not allow this awareness to become an impediment to progress or to the decisions that need to be made. Ethicists always seem to have more questions than answers, and unanswered questions often have a paralyzing effect. The continuing education of physicians should include the discussion of ethics, not necessarily to reach decisions, but as a validation that ethical analysis is an important part of medical practice and that different decisions can be based on identifiable principles. The ethicist becomes, not the conscience of medicine, but a force for making consistent thoughtful decisions. The variation in situations, individuals, and decisions to be made are seemingly beyond the ability of any one person always to be able to make proper decisions. The use of ethics and ethical consultation provides a diffusion of responsibility and decision making which well may satisfy and allay the anxieties of modern society when dealing with those matters of life and death in which they have little understanding and even less comfort.

This trend toward covenant-making ethics must not be allowed to develop into a paralysis of action, but hopefully will produce an enrichment of the responsibility for individual physicians. At the same time, this trend will help lay people to know more about the potential effects of technological advance, thereby allowing a greater participation in the decisions affecting themselves and their loved ones.

This does not relieve the physician of the ultimate decision, but it does give a process from which and on which to make recommendations and decisions, hopefully, to the best interest of the people served. And this is, after all, the greatest responsibility we have.

Current Patterns of Acute Renal Failure

ANTHONY A. DONATELLI, M.D., Plainfield*

Five causes of acute renal failure are presented. These include: radiographic contrast media; nontraumatic rhabdomyolysis and myoglobinuria; traumatic rhabdomyolysis and myoglobinuria; hemoglobinuric renal failure and antibiotics. Eight cases of acute renal failure from the above causes are discussed with special regard to possible adverse effects of drugs and diagnostic studies.

Acute renal failure is a serious problem experienced by the hospitalized patient and is a common accompaniment of a variety of illnesses. Although patients may be admitted to a hospital while in acute renal failure, the larger percentage of patients develop acute renal failure subsequent to hospitalization, which usually is associated with another illness or develops in conjunction with administration of drugs and certain diagnostic studies. It is, therefore, extremely important for the treating physician to be sensitive to those clinical situations in which acute renal failure may occur and especially which diagnostic studies and drugs may cause or contribute to the development of acute renal failure.

In the past few years clinical information has accumulated relative to two newly appreciated causes of acute renal failure: (1) that due to non-traumatic rhabdomyolysis with myoglobinuria; and (2) that due to radiographic contrast media, particularly in patients with diabetes mellitus. In addition, acute renal failure from antibiotics, traumatic rhabdomyolysis and hemoglobinuria also are deserving of comment and discussion.

This paper will discuss five causes of acute renal failure seen at Muhlenberg Hospital, a university-affiliated community teaching hospital. Each cause will be illustrated by case reports followed by appropriate comments and discussion.

CAUSES OF ACUTE RENAL FAILURE SEEN AT MUHLENBERG HOSPITAL

1. Radiographic contrast media
2. Non-traumatic rhabdomyolysis and myoglobinuria
3. Traumatic rhabdomyolysis and myoglobinuria
4. Hemoglobinuric renal failure
5. Antibiotics (aminoglycosides, methicillin, peptides)

CASE REPORTS

Case 1—Radiographic Contrast Media—An 82-year-old male was admitted to Muhlenberg Hospital because of right flank pain. The patient was known to have adult-onset diabetes for over twenty years. The diabetes was well controlled with diet and chlorpropamide (Diabinese®). The patient had long-standing essential hypertension and hypertensive arteriosclerotic heart disease with coronary insufficiency and angina pectoris. Compensated renal insufficiency due to nephrosclerosis had been present for two years; the serum creatinine had been stable at a level of six mg/dl. Medications prior to admission included propranolol hydrochloride (Inderal®), isosorbide dinitrate (Isordil®),

Dr. Donatelli is Chief of Nephrology and Director of the Hemodialysis Unit at Muhlenberg Hospital, Plainfield, and Clinical Associate Professor of Nephrology at Rutgers Medical School, CMDNJ, Piscataway. He may be addressed at 1010 Park Avenue, Plainfield, NJ 07060.

“Risk factors . . . include advanced age (over 60), preexisting renal insufficiency, dehydration, multiple myeloma and hyperuricemia.”

“... radiographic contrast media poses a significant hazard to certain patients. . .”

furosemide (Lasix®), nitroglycerin, digoxin (Lanoxin®) and chlorpropamide (Diabinese®). No additional medications were used. On the second hospital day, an intravenous pyelogram was performed. Shortly thereafter the patient became oliguric and a hyperkalemic metabolic acidosis ensued. Serum potassium was 6.2 mEq/l and total carbon dioxide was 12 mEq/l. When seen in consultation the patient appeared well and offered no complaints. Physical examination revealed blood pressure of 160/80 bilaterally, pulse 68, respirations 18 and temperature 99.8°F. Tissue turgor was satisfactory and no edema was present. The remainder of the physical examination was noncontributory.

The serum creatinine reached a peak of 12.0 mg/dl. The patient underwent a single peritoneal dialysis for oliguric renal failure. Following a five-day period of oliguria the patient began a step-wise diuresis and no further dialysis was needed. The serum creatinine subsequently stabilized at 6.5 mg/dl and the patient was discharged on the fifteenth hospital day. Eighteen months later the patient's serum creatinine was 6.4 mg/dl. No cause for the flank pain was found.

Case 2—Radiographic Contrast Media—A 78-year-old male was admitted to Muhlenberg Hospital because of gangrene of the right big toe. The patient was known to have adult-onset diabetes of greater than twenty years' duration; during the previous five years he required insulin for control. Medications prior to admission included Lente Insulin® and digoxin (Lanoxin®). Significant physical findings on admission were a blood pressure of 150/90 bilaterally and absent right dorsalis pedis and posterior tibial pulses. These pulses were barely palpable in the left foot. The remainder of the physical examination was noncontributory. Initial blood tests revealed a serum creatinine of 2.5 mg/dl; further investigation confirmed that this abnormality had been present for at least four months and was attributed to chronic interstitial nephritis due to nephrosclerosis. Shortly after admission the patient underwent an angiogram and thereafter developed worsening of his renal failure with the serum creatinine rising to a peak of 7.5 mg/dl. The patient was managed without dialysis and fifteen days later the creatinine returned to its previous baseline level.

COMMENT

Acute renal failure occurring after the use of radiographic contrast media is now a well-recognized entity and numerous reports have attested this to be a serious complication in both nondiabetic and diabetic patients. Although initially they were thought to be free of renal toxicity, acute renal failure or worsening of preexisting renal failure has been known to occur following the use of excretory urography and angiography, intravenous cholangiography and oral cholecystography.¹ Possible mechanisms of contrast-induced acute renal

failure include direct tubular toxicity, renal ischemia in the microcirculation causing slowing of flow with aggregation of red blood cells and intratubular obstruction by uric acid crystals, Tamm-Horsfall mucoprotein or lightchains.²

Risk factors which appear to play a role in both the nondiabetic and diabetic patient include advanced age (over 60), preexisting renal insufficiency, dehydration, multiple myeloma and hyperuricemia.³ The diabetic patient is at particular risk to develop renal failure following the use of contrast media particularly if he has preexisting renal disease and early-onset diabetes. Harkonen and Kjellstrand noted that 76 percent of diabetic patients with a creatinine level of more than two mg/dl had exacerbation of renal failure following intravenous pyelography.⁴ Particularly at risk seem to be patients with early-onset diabetes (less than 40 years) and those patients with severe renal failure (creatinine over five mg/dl). Ninety-three percent of such patients had problems after intravenous pyelography; of these 56 percent had irreversible deterioration. The course of acute renal failure in such patients is fairly characteristic; most patients recover but some do not. Oliguria is usually of brief duration (one to five days) and the serum creatinine usually peaks within seven days after contrast exposure. Dialysis is used as indicated but most reported series describe this syndrome as being self-limited with dialysis frequently unnecessary.^{5,6} Cases one and two in this report tend to corroborate this impression.

It is concluded that use of radiographic contrast media poses a significant hazard to certain patients and alternate diagnostic procedures and caution with contrast dosage and patient preparation may be wise. Control of blood volume and serum uric acid, appropriate spacing of radiographic studies and careful assessment of risk versus benefit for every proposed procedure is recommended to decrease the incidence and morbidity of contrast media acute renal failure.

Case 3—Non-traumatic Rhabdomyolysis and Myoglobinuria—A 40-year-old male was admitted to Muhlenberg Hospital after being seen in the emergency room complaining of muscle aches, stiffness and increasing weakness. The patient who was known to be a “binge drinker,” consumed large amounts of ethanol during the several days prior to admission. Physical examination revealed an acutely ill male with a blood pressure of 130/80 in each arm. The patient was able to walk but was unsteady while standing. Marked tenderness and weakness were present in all extremity muscle groups. Neurologic examination was unremarkable except for muscle weakness and hypoaffective deep tendon reflexes. The remainder of the physical examination was noncontributory. Initial blood studies confirmed the presence of a hyperkalemic metabolic acidosis and the patient was found to be in oliguric renal failure. Serum potassium was 5.9 mEq/l and total carbon dioxide content

"Acute renal failure occurring in association with myoglobinuria long has been recognized as a major complication of crushing injuries, since the Second World War."

"... primary causes for non-traumatic rhabdomyolysis and myoglobinuria include ... acute exertion, heart stress, enzyme deficiencies ... muscle disease ..., drugs ..., toxins ..., infectious agents and hypoglycemia."

was 14 mEq/l. Urinalysis showed a strongly positive test for occult blood using the orthotolidine method, while close evaluation of the urinary sediment revealed many pigmented granular casts. Subsequent blood tests confirmed very high levels of creatine phosphokinase (CPK) (>100,000), lactic dehydrogenase (LDH) and glutamic oxaloacetic transaminase (SGOT). Initial urine samples were subsequently found to contain myoglobin using the counter immunoelectrophoresis method. The patient underwent nine hemodialyses for management of oliguric renal failure and began a step-wise diuresis on the eleventh hospital day. The serum creatinine reached a peak of 22.0 mg/dl. The patient suffered from a complicating pneumonia which responded well to erythromycin (Ilotycin®) therapy. Admission symptoms gradually resolved and the patient was discharged on the twenty-first hospital day. Three weeks following discharge the serum creatinine was 1.1 mg/dl and the CPK was 189 units. The patient was told of the dangers of drinking ethanol.

Case 4—Traumatic Rhabdomyolysis and Myoglobinuria—A 35-year-old male was admitted to Muhlenberg Hospital three days following an automobile accident resulting in an injury to his right leg. The patient was confused and disoriented and complained of pain in his right leg. Physical examination revealed a blood pressure of 130/85 in each arm. There was swelling and diffuse ecchymosis of the right leg and foot. Peripheral pulses in the right foot were diminished and shortly thereafter were not palpable. The remainder of the physical examination was noncontributory. Initial blood tests revealed a hyperkalemic metabolic acidosis and evidence of uremia with a blood urea nitrogen (BUN) of 105 mg/dl and serum creatinine of 8 mg/dl. Serum potassium was 6.0 mEq/l and total carbon dioxide was 12 mEq/l. Urinalysis showed a strongly positive orthotolidine test for occult blood and the urinary sediment revealed many pigmented granular casts. Initial urine collection later proved to be positive for myoglobin using the counter-immunoelectrophoresis method. Blood test results showed markedly elevated lactic dehydrogenase (LDH) and serum glutamic oxaloacetic transaminase (SGOT) levels. Creatine phosphokinase (CPK) levels were greater than 50,000 units. The patient underwent an emergency fasciotomy of the distal right leg for relief of the anterior compartment syndrome and shortly thereafter underwent a five-hour hemodialysis. The patient remained in oliguric renal failure and required ten hemodialysis treatments for control of renal failure. On the fifteenth hospital day the patient began a step-wise diuresis and the serum creatinine subsequently stabilized at 0.9 mg/dl. The patient had a split-thickness graft to the right leg and was discharged on the forty-fourth hospital day. Six months following discharge the serum creatinine was 1.2 mg/dl and the right leg had healed nicely. Peripheral pulses were normal in the right foot.

Case 5—Hemoglobinuric Renal Failure—A 33-year-old male was transferred to Muhlenberg Hospital for further evaluation and treatment of acute anuric renal failure following administration of two units of incompatible blood. The transfusion reaction occurred at another hospital from which the patient was transferred shortly following elective surgery for correction of fistulas complicating long-standing regional ileitis. The patient noted passage of dark urine and shaking chills closely following the blood transfusions and shortly thereafter became anuric and subsequently jaundiced. Immediate sampling of blood and urine confirmed hemoglobinemia and hemoglobinuria. Physical examination at time of transfer revealed a blood pressure of 140/90 bilaterally. The patient appeared well without evidence of dehydration or edema. A healing incisional scar was present on the abdomen. The remainder of the physical examination was noncontributory. Blood tests revealed a blood urea nitrogen of 120 mg/dl and a serum creatinine of 15 mg/dl, serum sodium 130 mEq/l, serum chloride 95 mEq/l, serum potassium 5.6 mEq/l and total carbon dioxide 14 mEq/l. The patient underwent eight hemodialysis treatments for management of anuric renal failure and on the fourteenth hospital day a diuresis began in step-wise fashion. Six months following discharge the patient's serum creatinine was 1.1 mg/dl.

COMMENT

Cases three, four and five are grouped together to discuss and compare myoglobinuric and hemoglobinuric renal failure.

Acute renal failure occurring in association with myoglobinuria long has been recognized as a major complication of crushing injuries since the Second World War.

During the ensuing years sporadic reports have appeared linking myoglobinuria with acute renal failure in the absence of overt trauma. This non-traumatic form of rhabdomyolysis with myoglobinuria and acute renal failure is now a well-recognized clinical entity and has been reported with increasing frequency during the past several years. Several clinical conditions now have been recognized as primary causes for nontraumatic rhabdomyolysis and myoglobinuria.² They include: (1) acute exertion (2) heart stress; (3) enzyme deficiencies: a) carnitine palmityl transferase, b) phosphophorylase (McArdle's disease), c) phosphofructokinase (Tarvi's disease); (4) muscle diseases: a) muscular dystrophies, b) polymyositis, c) dermatomyositis; (5) drugs: a) alcohol, b) heroin, c) amphetamines, d) phenylcyclidine; (6) toxins (Haff disease); (7) infectious agents; and (8) hypoglycemia.

Alcohol as a cause for nontraumatic rhabdomyolysis with myoglobinuria and acute renal failure is illustrated in case three and is well recognized as a cause of myopathy in both heart and skeletal muscle.⁷ An understanding of the

"The mechanism by which heme pigments cause acute renal failure is unclear."

pathogenesis of alcohol-induced injury in both heart and skeletal muscle requires an appreciation of subcellular processes, of the effects of acute and chronic consumption of alcohol and of changes in subcellular constituents of muscle fibers caused by the presence of ethanol and acetaldehyde. Perkoff, *et al.*⁸ and Rubin⁷ present a more detailed discussion of this problem.

Sporadic reports of acute renal failure occurring with hemoglobinuria in the absence of other definable causes continue to raise the question concerning the potential of hemoglobin as a nephrotoxic substance.⁹ Case five, however, clearly points out the danger of transfusion reactions as a cause of hemoglobinuria and acute renal failure.

The mechanism by which heme pigments cause acute renal failure is unclear. Hypotheses have included plugging of tubules by myoglobin- or hemoglobin-containing casts, passive back diffusion of glomerular filtrate through damaged tubular epithelial cells or a decrease in glomerular filtration rate.¹⁰

Contributing to the increasing awareness of these conditions is the ability to identify myoglobin in the urine and to differentiate it from hemoglobin. Myoglobin is a heme pigment with a molecular weight of 17,800 and is freely filterable at serum concentrations less than 15 mg/dl. It contains iron in association with a pyrole nucleus and therefore gives a positive reaction with benzidine and orthotolidine. Because of this, it is frequently confused with hemoglobin. Hemoglobin has a molecular weight of 78,000, four times that of myoglobin. When hemolysis occurs hemoglobin is released and the globin moiety is bound to haptoglobin while heme binding occurs with hemopectin. When the binding capacity of these substances is exceeded, hemoglobin then appears in the plasma and urine. Consequently, a positive orthotolidine reaction of the urine is indicative of the presence of hemoglobin only if a similar positive reaction can be obtained in the plasma and it can be demonstrated that the serum haptoglobin levels are depressed. In the absence of these findings, a positive orthotolidine is suggestive of myoglobin. The most reliable means of identifying myoglobin is by acrylamide gel electrophoresis or immunoassay as done in cases three and four. However, the triad of orthotolidine positive urine, pigmented granular casts and a markedly elevated creatine phosphokinase (CPK) in the appropriate clinical setting strongly suggests the presence of rhabdomyolysis and myoglobinuria.

The prognosis of acute renal failure associated with both myoglobinuria and hemoglobinuria is good and as a rule the underlying precipitating illness governs the patient's ultimate prognosis.

Case 6—Antibiotics (aminoglycosides)—A 66-year-old male was admitted to Muhlenberg Hospital with intermittent claudication involving both lower extremities. Physical ex-

"The prognosis of acute renal failure associated with both myoglobinuria and hemoglobinuria is good. . ."

amination on admission revealed a well-developed man appearing his stated age and complaining of pain and discomfort in his right foot. Blood pressure was 160/90 in both arms and no popliteal, dorsalis pedis or posterior tibial pulses were present in the right leg. These pulses were present but diminished in the left leg. An ischemic ulcer was present in the right big toe and the foot was cool. The remainder of the physical examination was noncontributory. Admission blood urea nitrogen was 18 mg/dl and serum creatinine was 1.4 mg/dl. Electrolytes were normal. Initial urinalysis showed specific gravity of 1.018 and was negative for blood, protein and glucose. The urinary sediment failed to show abnormal cellular elements and no casts were seen. The patient underwent a right, above-knee amputation which was complicated by a wound infection; he was treated with a twenty-one day course of gentamicin sulfate (Garamycin®) at daily doses of 320 mg. Four days following cessation of antibiotics the patient was seen in consultation because of non-oliguric renal insufficiency. Serum creatinine had risen to 4.3 mg/dl and blood urea nitrogen had risen to 60 mg/dl. Electrolytes were normal. The patient appeared well hydrated; he was afebrile and offered no complaints. Urinalysis showed specific gravity of 1.010, 1+ protein by sulfosalicylic acid and on microscopic examination of the urinary sediment "sheets" of renal tubular cells were found. The patient was managed for acute renal failure without dialysis and had an uneventful recovery relative to renal function. Four months following discharge serum creatinine was 1.5 mg/dl.

Case 7—Antibiotics (Aminoglycosides peptides)—An 83-year-old lady was admitted to Muhlenberg Hospital with an ulcer of the left leg. Physical examination revealed a blood pressure of 160/80 in both arms. A right carotid artery bruit and aortic systolic ejection murmur were present. There were diminished peripheral pulses in both legs and a well-demarcated ulcer was present on the distal lateral surface of the left leg. The remainder of the physical examination was noncontributory. Admission serum creatinine was 1.2 mg/dl and blood urea nitrogen was 15 mg/dl. Electrolytes were normal. Initial urinalysis showed specific gravity of 1.015, no blood, protein or glucose; the urinary sediment revealed no abnormalities other than four to five white blood cells per high-powered field. The patient was treated with a twelve-day course of gentamicin sulfate (Garamycin®) followed by an eleven-day course of colistin (Coly-Mycin®M). Three days after cessation of antibiotics the patient was seen in consultation for non-oliguric renal insufficiency. Serum creatinine had risen to 6.3 mg/dl and blood urea nitrogen had risen to 80 mg/dl. Electrolytes were normal. Urinalysis showed specific gravity of 1.010, 2+ protein by sulfosalicylic acid, 1+ occult blood by dip-stick (orthotolidine) and no glucose. Many granular casts and numerous renal tubular cells per

high-powered field were seen on microscopic examination of the urinary sediment. The patient offered no complaints, appeared well hydrated and had an uneventful recovery following a split thickness graft to the left leg. The patient's acute renal failure was managed without dialysis and the serum creatinine was 1.4 mg/dl prior to discharge.

Case 8—Antibiotics [methicillin] (Staphicillin®)—A 67-year-old man was admitted with intermittent claudication primarily involving the left leg. Physical examination revealed a blood pressure of 160/90 in both arms. Diminished peripheral pulses were present in both legs and a diminished femoral artery pulse together with a bruit was present in the left groin. The remainder of the physical examination was noncontributory. It was elected to bypass the obstructed vessel in the left leg via an aorticofemoral bypass gor-tex graft. Prior to surgery blood urea nitrogen was 1.5 mg/dl and serum creatinine was 1.5 mg/dl. Urinalysis was negative for blood, protein and glucose. Specific gravity was 1.018. An aorticofemoral bypass was done which was followed by a staphylococcus aureus bacteremia. The patient was treated with methicillin (Staphicillin®) 8 gm daily for twenty-one days. On the twentieth day of antibiotic therapy, fever recurred and a rash and eosinophilia were found. Acute interstitial nephritis secondary to methicillin was suspected so it was discontinued. Blood urea nitrogen had risen to 40 mg/dl and serum creatinine had risen to 3.0 mg/dl. Urinalysis showed specific gravity of 1.010, no glucose, 2+ protein by sulfosalicylic acid and 2+ positive for occult blood by orthotolidine test. Microscopic examination of the urinary sediment showed 8 to 10 red blood cells per high powered field and many granular casts. Electrolytes remained normal. The non-oliguric acute renal insufficiency was managed without dialysis and systemic symptoms responded well to decreasing doses of prednisone given over a period of ten days. Serum creatinine reached a peak of 6.0 mg/dl. Six months following discharge serum creatinine was 1.5 mg/dl and the urine was free of protein and blood. Microscopic examination of the urinary sediment showed two to three white blood cells per high powered field and no red blood cells. An occasional granular cast was seen.

COMMENT

Acute renal failure related to methicillin (Staphicillin®) has been well documented¹¹ and is due to interstitial nephritis with interstitial infiltrate of mononuclear cells and eosinophils, accompanied by tubular damage. The glomeruli and blood vessels have been described as normal. Antitubular basement membrane antibodies have been described and a methicillin antigen shown to be dimethoxyphenylpenicilloyl is believed to be part of the "hapten protein conjugate" responsible for the immune response in the pathogenesis of this type of interstitial nephritis.¹¹ The renal disease is usually mild and characterized by polyuria and salt wasting. Renal function usually returns to normal and occasionally dialytic care is necessary. Steroids have been found useful for fever and rash. Renal tubular acidosis associated with this entity has been reported.¹² Potentially less nephrotoxic antistaphylococcal drugs are now available for use and should be used in place of methicillin (Staphicillin®).

The aminoglycosides have become the most relied on antibiotics in the treatment of gram-negative bacterial infections and are well recognized as a cause of renal failure. A continuing search goes on to find less toxic aminoglycosides but presently all aminoglycosides pose this threat. The

"Acute renal failure related to methicillin . . . is due to interstitial nephritis . . ."

nephrotoxicity of the aminoglycosides probably relates to tissue-binding in the renal cortex¹³ and the degree of tissue-binding appears to correlate with the number of free amino groups contained in a given agent.¹⁴

Several factors are known to predispose patients to the development of aminoglycoside nephrotoxicity. These include: (1) advancing age, (2) preexistent renal dysfunction, (3) volume depletion and (4) recent exposure to another aminoglycoside or another nephrotoxic agent.¹⁵ The combination of gentamicin sulfate (Garamycin®) and cephalothin sodium (Keflin®) is particularly toxic in patients with chronic renal failure and should be avoided unless absolutely necessary.¹⁶

The clinical course of acute renal failure is usually mild, self-limited and characterized by non-oliguria. It is gradual in onset and related to the dose and duration of drug administration. Both cases six and seven were characterized in this manner. Numerous reports point out the value of obtaining aminoglycoside blood levels and of adjusting aminoglycoside dosage relative to renal function and changes prior to, during and after peritoneal and hemodialysis.¹⁷

Case seven was treated with both gentamicin sulfate (Garamycin®) and colistin (Coly-Mycin®M) and illustrates the danger of using two potential nephrotoxic drugs in close succession of one another without close monitoring of renal function and urinalysis.

Colistin, a cyclic polypeptide, has toxic effects both on the respiratory center and on the kidneys and fortunately is being used with decreasing frequency. The course of renal failure associated with colistin is similar to that of gentamicin sulfate.

Although none of the above case reports received cephalosporins this drug is so commonly used that it is deserving of mention. It formerly was thought that cephaloridine (Loridine®) alone was nephrotoxic but it is now apparent that cephalothin sodium (Keflin®)¹⁸ and cephalixin (Keflex®)¹⁹ are also nephrotoxic. Drug allergy and interstitial nephritis are believed to play a role in the pathogenesis of this entity. Furosemide (Lasix®) may enhance toxicity of cephalosporin, and consideration of an alternate diuretic should be considered²⁰ when such an agent is needed in a patient who is receiving or is to receive cephalosporin antibiotics.

SUMMARY

Acute renal failure is a serious problem experienced by the hospitalized patient and is associated with significant morbidity. Although patients may be admitted to a hospital while in acute renal failure, the larger percentage of patients develop acute renal failure following hospitalization and frequently can be attributed to associated illnesses, administration of drugs and performance of certain diagnostic studies.

Eight cases of acute renal failure from a variety of causes are presented and depicted as current patterns of acute renal failure seen in a northeastern community teaching hospital and discussed in relation to etiology and outcome. Since the majority of acute renal failure cases occur following hospital admission, it is important that the clinician recognize commonly associated illnesses which may be related causally to the development of this serious complication. Equally important is the knowledge that acute renal failure is not infrequently associated with certain diagnostic studies and administration of a variety of drugs. The physician carefully must assess risk versus benefit for each diagnostic study as well as administration of potential nephrotoxic drugs.

REFERENCES

1. Byrd L, Sherman RL: Radio-contrast-induced acute renal failure. *Med* 58:270-279, 1979.
2. Mattern WD, Finn WF: Changing perceptions of acute renal failure. *The Kidney* (Nat Kid Found) 11:25-29, 1978.
3. VanZee BE, Hay WE, Talley TE, Jaenike JR: Renal injury associated with intravenous pyelography in nondiabetic and diabetic patients. *Ann Intern Med* 89:51-54, 1978.
4. Harkonen S, Kjellstrand CM: Exacerbation of diabetic renal failure following intravenous pyelography. *Am J Med* 63:939-946, 1977.
5. DiAx-Buxo JA, Wagoner RD, Hattery RR, Palumbo PJ: Acute renal failure after excretory urography in diabetic patients. *Ann Intern Med* 83:155-158, 1975.

6. Barshay ME, Kaye JH, Goldman R: Acute renal failure in diabetic patients after intravenous infusion pyelography. *Clin Nephrol* 1:35-39, 1973.
7. Rubin E: Alcoholic myopathy in heart and skeletal muscle. *N Engl J Med* 301:28-33, 1979.
8. Perkoff GT, Hardy P, Velez-Garcia E: Reversible acute muscular syndrome in chronic alcoholism. *N Engl J Med* 274:1277-1285, 1966.
9. Schrier RW: Acute renal failure. *Kid Int* 15:205-216, 1979.
10. Grossman RA, Hamilton RW, Morse BM, Penn AS, Goldberg M: Non-traumatic rhabdomyolysis and acute renal failure. *N Engl J Med* 291:807-811, 1974.
11. Border WA, Lehman DH, Egan JD, Sass HJ, Glode JE, Wilson CB: Antitubular basement-membrane antibodies in methicillin-associated interstitial nephritis. *N Engl J Med* 291:381-384, 1974.
12. Schrier RW, Bulger RJ, VanArsdel PP: Nephropathy associated with penicillin and homologues. *Ann Intern Med* 64:116-127, 1966.
13. Luft FC, Yum MN, Patel B, Kleit SA: Experimental aminoglycoside nephrotoxicity. *J Lab Clin Med* 86:213-220, 1970.
14. Kunin CM: Binding of antibiotics to tissue homogenates. *J Infect Dis* 121:55-64, 1970.
15. Lane AZ, Wright GE, Blair DC: Ototoxicity of amikacin. *Am J Med* 62:911-918, 1977.
16. Kleinknecht D, Ganeval D, Droz D: Acute renal failure after high doses of gentamicin and cephalothin. *Lancet* 1:1129, 1973.
17. Chan RA, Benner J, Hoepfich PD: Gentamicin therapy in renal failure. *Ann Intern Med* 76:773-778, 1972.
18. Thomas BL: Renal function and cephalothin. *N Engl J Med* 280: 505-506, 1969.
19. Fung-Herrera CG, Mulvaney WP: Cephalixin nephrotoxicity. *JAMA* 229:318-319, 1974.
20. Linton AL, Bailey RR, Turnbull DI: Relative nephrotoxicity of cephalosporin antibiotics in an animal model. *Can Med Assoc J* 107:414-416, 1972.

Maternal Deaths in New Jersey - 1979*

JAMES P. THOMPSON, M.D., Paterson

Twenty-seven maternal deaths occurred in New Jersey in 1979. This figure is identical to that of the previous year but etiology differed somewhat. Subarachnoid hemorrhage, postcesarean section pulmonary emboli, postabortal sepsis, ruptured ectopic pregnancy, and anesthesia-related deaths accounted for almost two-thirds of the deaths. A detailed review of the case histories is presented.

The enhanced effort to decrease the incidence of maternal deaths in New Jersey by the process of systematic case review and educational programs directed toward eradication of the common causes has not met with great success to date.^{1,2} The principal characteristic of this review has been the wide gamut of contributing factors implicated and this has precluded the homing in on one disease process or practice pattern in an attempt to reduce the number. In 1977 pregnancy-related hypertension was thought to be a factor in 38 percent of the deaths; during the course of the next year educational efforts were directed along these lines and in 1978 only one of twenty-seven deaths was associated with pregnancy-related hypertension. Anesthesia-related factors were the most commonly noted in 1978; educational efforts are continuing along these lines to alert both obstetricians and anesthesiologists to the unique risks posed by the pregnant patient.

Reports of this type are only as valuable as the quality and quantity of information supplied to the Maternal Mortality Subcommittee for review. The investigatory activities of the "field physician"—long a tradition with previous committees—have been supplanted by requests of the State Department of Health to hospital administrators for copies of the medical record of the deceased. In a minority of instances the material submitted is found lacking and this detracts from the factual accuracy of the final report. Hospital, physician, and patient anonymity are respected to the utmost and a plea

is made to administrators, departmental chairmen, and attending obstetricians to report promptly to the State Department of Health the occurrence of a maternal death. In addition, the request for a copy of the medical record should be honored so that just consideration of the facts surrounding the maternal death may ensue.

The New Jersey Obstetrical and Gynecological Society has generously allotted time at its most recent annual meetings to a discussion of trends and specific case reports of maternal deaths occurring in the preceding year. The main thrust of the educational efforts should be directed toward smaller group discussions at the institution of occurrence. The rationale for the latter is not to level incriminatory charges but rather to share the deliberations of the Committee with an empathetic group drawn together by a colleague's loss of a pregnant patient.

RESULTS

There were 95,672 live births in New Jersey in 1979; 27 maternal deaths were identified and presented to the Committee for study. There was a 2.5 percent increase in the number of births from the preceding year but the number of maternal deaths was identical. Table 1 presents the classification and rates as suggested by the American College of

*From St. Joseph's Hospital and Medical Center, Department of Obstetrics and Gynecology, Paterson, where Dr. Thompson is Chairman of the Department. He may be addressed there, 703 Main Street, Paterson 07503.

Table 1
Classification and Mortality Rates

Live Births	95,672
Maternal Deaths	27
Non-maternal	2
Indirect	7
Direct	18
Rate (indirect only)	8/100,000 live births
Rate (direct only)	19/100,000 live births
Rate (all causes)	28/100,000 live births

Table 2
Characteristics by Race, Age and Prenatal Care

Race	Number	Percent
White	14	51
Non-White	13	49
Age		
Less than 20	3	11
20 - 34	19	70
35 - 39	4	15
Greater than 40	1	4
Prenatal Care		
None	0	0
Inadequate	2	8
Unknown	3	11
Adequate	16	59
Excluded	6	22

Obstetricians and Gynecologists.³

Two deaths occurred out of hospital—one patient died in a fire at home and another was found dead of a ruptured ectopic pregnancy in her automobile. The remainder occurred in twenty different hospitals throughout the State. Among the hospitalized patients, twelve expired in intensive care units; five in the emergency treatment area and four in the obstetrical area. Two deaths occurred on medical floors and two in the operating suite. Five of the patients expired undelivered; eight followed vaginal delivery and twelve followed cesarean section. It is interesting to note that the latter group included four patients who had repeat cesarean sections; three were done for cephalopelvic disproportion or fetal distress and five were performed for the complication that ultimately led to their death.

Tables 2 and 3 describe race, age, prenatal care, parity and gestational age. Five of the twenty-one patients eligible for prenatal care received less than adequate care. Three patients were nulliparous.

PATHOLOGICAL REVIEW

Autopsy reports were available for fifteen patients and, as in past years, a clinical diagnosis was assigned by the Committee to the remainder. Despite postmortem study the cause of death remained unexplained in two patients. One patient experienced symptoms of a cardiac arrhythmia and pulmonary edema at sixteen weeks gestation following ingestion of a meal. Pathologic study revealed the presence of pulmonary edema with no identifiable cause and no cardiac pathology. A second patient with a history of intraductal breast carcinoma and psychiatric disease expired at fifteen weeks gestation while undergoing a diagnostic evaluation for generalized weakness. Postmortem study revealed no evidence of breast carcinoma and toxicologic studies were negative.

Table 4 lists the nonobstetric causes of death and Table 5 lists deaths due to direct obstetric causes. Table 6 is a

Table 3
Parity and Duration of Pregnancy

Parity	Number	Percent
0	3	11
1 - 3	19	70
4 - 6	4	15
Unknown	1	4
Gestational Age		
Less than 20 weeks	7	25
20 - 28	2	8
29 - 40	15	56
Postabortal	3	11

Table 4
Pathologic Diagnoses for Non-Maternal,
Indirect Obstetric Deaths

Non-maternal		
Fire	1	
Auto accident	1	
Indirect		
Cerebrovascular hemorrhage		3
Subarachnoid hemorrhage	3	
Ruptured brain cyst		1
Thrombotic thrombocytopenia		1
Unexplained		2

Table 5
Pathologic Diagnoses for Direct Obstetric Deaths

Hemorrhage		4
Ectopic pregnancy	3	
Placenta increta	1	
Infection		4
Pneumonia	1	
Chorio-amnionitis	1	
Postabortal sepsis	2	
Anesthesia		3
General	3	
Hypertension		1
Cerebrovascular hemorrhage	1	
Respiratory disease		4
Pulmonary embolus	4	
Miscellaneous		2
Amniotic fluid embolus	1	
Water intoxication	1	

Table 6
Preventability of Maternal Deaths

A. Indirect causes		7
Non-preventable	7	
B. Direct causes		18
Non-preventable	9	
Preventable	9	
1. Physician factor	8	
2. Patient factor	1	

summation of the nonpreventable and preventable deaths, including an assignment of contributory factors in the preventable deaths.

DISCUSSION

The categorization of a nonmaternal or nonobstetric-related death is thought by some to inflate needlessly the maternal mortality rate. Others feel that to classify maternal

"Of the seven indirect maternal deaths four were associated with subarachnoid hemorrhage . . ."

"The obstetrician should be alerted to the occurrence of diplopia, visual or hearing loss and confusion with headache as suggestive of the presence on a subarachnoid hemorrhage."

death as being "nonmaternal" is a semantic redundancy. These objections appear legitimate but in an effort to present the total picture in the State, deaths due to nonobstetric-related causes are included in this report. There were two such maternal deaths in 1979. One occurred postpartum in which the patient and her entire family died of asphyxiation in a fire in their home. The second occurred at thirty-six weeks gestation as a result of an automobile accident. Upon admission to the emergency treatment area, a cesarean section was carried out and upon entry into the abdominal cavity a totally abrupted placenta was noted to be lying free. It had exited through a 12 cm. laceration in the anterior wall of the uterus and a stillborn infant was delivered through the laceration. It was not known if the patient was wearing a seat belt at the time of the accident.

Of the seven indirect maternal deaths four were associated with subarachnoid hemorrhage; two were unexplained and one was associated with a hemorrhagic diathesis thought to be consistent with thrombotic thrombocytopenic purpura. None of the seven was deemed preventable.

Recent reports of maternal mortality reviews suggest that subarachnoid hemorrhage associated with maternal deaths is not uncommon.^{4,5} Three patients had "classic" subarachnoid hemorrhage involving the internal carotid and anterior cerebral arteries while the fourth ruptured a brain cyst with resultant hemorrhage into the subdural and subarachnoid spaces. Their ages ranged from 26 to 41 years and the periods of gestation were from 24 to 38 weeks. All four presented with a headache and three had an associated seizure or lapse of consciousness soon after. Two expired within eight hours of admission and two survived for a week. Three of the four delivered live infants—two by cesarean section. None was deemed stable enough or survived long enough to undergo definitive neurosurgical intervention. While sudden headache, vomiting, and loss of consciousness are present in the majority of patients presenting with a subarachnoid hemorrhage, as many as ten percent have a gradual development of symptoms over a period of days.⁶ The obstetrician should be alerted to the occurrence of diplopia, visual or hearing loss and confusion with headache as suggestive of the presence of a subarachnoid hemorrhage. Prompt neurologic consultation is indicated; a lumbar puncture and CAT scan are useful diagnostic procedures. Among patients who survive the first twenty-four hours after a subarachnoid hemorrhage, 50 percent die of the illness within two weeks if appropriate therapy is not instituted.⁷

Eighteen maternal deaths were thought to be directly related to the pregnancy. Nine of these were considered nonpreventable: four due to pulmonary emboli; three due to ruptured ectopic pregnancies; one due to fulminant sepsis after rupture of the membranes; and one due to eclampsia

despite early and aggressive treatment.

All four of the patients that succumbed to a pulmonary embolus did so after cesarean section. Three were repeat operations and one was for cephalopelvic disproportion following an adequate trial of labor. The deaths occurred from six hours to eleven days postoperative. All had necropsy confirmation of the diagnosis. The expanding indications for cesarean section noted over the past decade should heighten our surveillance of this approach to be certain that the supposed benefits to the neonate outweigh the risks to the mother. Evrard and Gold found that the risk of death from cesarean section was twenty-six times greater than with vaginal delivery.⁸ They felt that in four of nine postcesarean deaths studied cesarean section per se was responsible. Evidence to the contrary^{9,10} suggests that significant reduction in the risk factors incumbent to the procedure itself can reduce greatly the risk of death to the patient. Obstetricians should be familiar with the mechanical and biochemical factors contributing to the hypercoagulable state of pregnancy and employ preventive measures preoperatively when indicated (leg wraps, avoidance of constricting straps on the operating table). Prompt diagnostic and therapeutic measures should be utilized postoperatively in patients with signs of phlebitis or thromboembolism.

Nine direct maternal deaths were thought preventable. Three deaths were due to anesthesia-related factors and three were due to sepsis (two postabortal and one postcesarean section). One death was due to amniotic fluid embolism following Pitocin® induction for an intrauterine demise and one due to hemorrhage secondary to a placenta increta found at the time of repeat cesarean section. In addition, one patient died because of water intoxication during the course of an indicated induction for preeclampsia. This suggests that a plea be made for continued awareness of the anti-diuretic properties of Pitocin® and the use of controlled infusion pumps during induction of labor.

The disturbing trend noted among anesthesia-related deaths due to faulty placement of the endotracheal tube has been noted previously.² One of the three maternal deaths in 1979 was due to this factor while the others were due to aspiration of gastric contents. For the first time in recent years abortion-related deaths were a significant factor accounting for 11 percent of the total. Sepsis after termination of pregnancy occurred in two of the three postabortal deaths with *Clostridium perfringens* and *Staphylococcus aureus* isolated on bacterial study. The third patient died of aspiration pneumonia after the use of general anesthesia to complete a prostaglandin-induced abortion. Similar to the expanding indications for cesarean section the liberalization of abortion calls for augmented surveillance to assess patient risk properly.

SUMMARY

Twenty-seven maternal deaths occurred among the 95,672 live births reported in New Jersey in 1979. This accounted for an overall rate of 28. Of more meaning is the rate of direct maternal deaths of 19/100,000 of which half were thought preventable. Infection and anesthesia-related causes accounted for the majority of the latter. A request is made for prompt reporting and adequate case reports to insure accuracy of maternal death studies in the State.

REFERENCES

1. Thompson JP: Maternal deaths in New Jersey—1977. *J Med Soc NJ* 76:735-737, 1979.

2. Thompson JP: Maternal deaths in New Jersey—1978. *J Med Soc NJ* 77:731-733, 1980.

3. *Standards for obstetric and gynecologic services*. American College of Obstetricians and Gynecologists, 1974, p. 75.

4. Rumbolz WL: 1978 Nebraska maternal mortality review. *Neb Med J* 65:3, 1980.

5. Barry AP, Bonnar J, Boyle JF, et al: IMA maternal mortality report 1978. *J Irish Med Assoc* 73:148-152, 1980.

6. Adams AP, Jergenson DD, Kassell NF, Sahs AL: Pitfalls in the recognition of subarachnoid hemorrhage. *JAMA* 244:794-796, 1980.

7. Sundt TM, Whisnant JP: Subarachnoid hemorrhage from intracranial aneurysm. *N Engl J Med* 229:116-122, 1978.

8. Evrard JR, Gold EM: Cesarean section and maternal mortality in Rhode Island. *Obstet Gynec.* 50:594-597, 1977.

9. Jones OH: Cesarean section in present-day obstetrics. *Am J Obstet Gynec.* 126:521-530, 1976.

10. Frigoletto FD, Ryan KJ, Phillippe M: Maternal mortality rate associated with cesarean section: An appraisal. *Am J Obstet Gynec* 136:969-970, 1980.

Endoscopy and Upper Gastrointestinal Tract Bleeding

JOEL D. LEVINSON, M.D., MICHAEL B. KERNER, M.D., Springfield*

Fiberoptic endoscopy markedly has increased our ability to diagnose correctly the causes of upper gastrointestinal tract bleeding. Its diagnostic accuracy is clearly superior to conventional radiography. However, endoscopy has not improved the outcome for the bleeding patient. This may reflect on the inadequacies of current therapy. The therapeutic potential of panendoscopy is currently under investigation.

Upper gastrointestinal bleeding is a protean disorder of many causes and complications. It is a common medical emergency, frequently requiring hospitalization. There are approximately fifty hospital admissions per 100,000 population yearly for this disorder.¹ Although eighty-five percent of bleeders stop spontaneously, approximately fifteen percent of patients require surgical intervention.² The mortality rate for upper gastrointestinal bleeding of ten percent has remained unchanged for over twenty-five years.³

A physician's experience and approach to upper gastrointestinal bleeding depends upon his level of training and expertise, the availability of diagnostic and therapeutic facilities, and the patient population with which he deals. Therefore, a review of this subject can offer guidelines rather than dictums. No guidelines can cover all contingencies, and situations will occur in which deviation from the usual approach is warranted. However, setting criteria for the management of a majority of patients with upper gastrointestinal bleeding is worthwhile and useful.

INITIAL CLINICAL APPROACH

The approach to the bleeding patient begins with initial resuscitative measures. These include inserting a large bore intravenous line, evaluation of vital signs, and laboratory studies which include blood counts, clotting studies, blood tests for type and crossmatch and blood chemistry screening.

An electrocardiogram and chest x-ray are done in all patients over fifty. Volume expansion is initiated and transfusion to hemoglobin levels above 10 gm/dl is advised.⁴

A brief history then is taken. It is important to know if there have been prior bleeding episodes. Symptoms such as heartburn, nocturnal dyspepsia, epigastric pain, weight loss, dysphagia, or violent retching may be valuable in narrowing the differential diagnosis. One should ask if a patient has a prior history of liver disease, a known bleeding disorder, or gastrointestinal surgery. Knowledge of all medications is essential, particularly aspirin-containing compounds, other anti-inflammatory agents, anticoagulants and alcohol. Other illnesses are reviewed since they may limit diagnostic and therapeutic options.

The physical examination should be directed toward estimating blood loss and suggesting possible bleeding sites. Signs of chronic liver disease are especially important if accompanied by portal hypertension. Skin lesions may indicate specific disorders. For example, mucosal telangiectasia suggests Osler-Weber-Rendu Syndrome. Gastric aspiration is a rapid method of localizing hemorrhage to the upper gastrointestinal tract, although an occasional patient with duodenal ulcer may have a negative aspirate.⁵ In conjunction with gastric aspiration, many will use gastric

*Drs. Levinson and Kerner are Clinical Assistant Professors of Medicine, New Jersey School of Medicine, CMDNJ, Newark. Correspondence may be addressed to Dr. Levinson at 55 Morris Avenue, Springfield, New Jersey 07081.

lavage as a simple way of assessing the presence and rate of continued bleeding, of monitoring the recurrence of bleeding and in evacuating clots to facilitate endoscopy.

Unfortunately, Scott found that thirty percent of initial diagnoses, based on the history, the physical examination and past medical records, were changed after the results of diagnostic procedures were known. His findings suggest that at least thirteen percent of the initial impressions would have led to inappropriate management.⁶ Others reported that mortality rates in gastrointestinal bleeding were higher when the diagnosis was unknown,⁷ and endorsed a "vigorous diagnostic approach" for the management of acute upper gastrointestinal hemorrhage.⁸ This method mandates that diagnostic efforts be initiated at the earliest possible moment consistent with safety. This assumes that early efforts can detect, with great accuracy, the location and nature of the bleeding lesion, and that treatment based upon an early, specific diagnosis will be more successful than non-specific measures.

FIBEROPTIC PANENDOSCOPY

The rapid development and utilization of fiberoptic panendoscopy over the past decade markedly has enhanced our ability correctly to diagnose many disorders of the gastrointestinal system. Rates of diagnostic accuracy over ninety percent are common.⁹ The diagnostic accuracy of early endoscopy is clearly superior to conventional and double-contrast barium radiography in the patient who is actively bleeding.⁹⁻¹¹ Thus, gastroenterologists concluded that endoscopy is the initial diagnostic procedure of choice in patients with upper gastrointestinal bleeding because it enables detection of even superficial bleeding lesions and significantly increases the speed of diagnosis.¹² The reasonable anticipation was that an early, correct diagnosis would lead to reduced morbidity and mortality.

This assumption has been much more difficult to establish. Some continue to assert that emergent endoscopy improves management and reduces morbidity and mortality.¹³ Others found that an aggressive approach to diagnosis coupled with aggressive management, e.g., early surgery for chronic gastric ulcer in the elderly, decreased mortality.¹⁴ Unfortunately, in several studies, the anticipated benefits of early diagnosis, such as reduced transfusion requirement, more rational use of surgery, decreased length of hospitalization and improved survival, have not been found.¹⁴⁻¹⁶

Most studies suggest that the diagnostic accuracy of panendoscopy remains high for the first twenty-four to forty-eight hours. This has led to the suggestion that panendoscopy is best performed at a time during the first forty-eight hours when the patient's vital signs are stable and when the full endoscopy team is available.¹⁷ Emergency endoscopy is reserved for patients with continued massive bleeding, or rebleeding, requiring an immediate decision regarding surgery or other treatment, such as balloon tamponade or angiography.¹⁷

CONTRAINDICATIONS, COMPLICATIONS, CONCEPTS AND CONTROVERSY

Emergency endoscopy is not for the inexperienced. It requires considerable technical skill and judgment as well as interpretive ability. Contraindications to endoscopy include severe myocardial ischemia or infarction, life-threatening cardiac arrhythmias, acute respiratory failure, delirium tremens or an uncooperative patient.⁹ In addition, the presence of abdominal pain in a patient with upper gastroin-

testinal hemorrhage should alert the physician to certain possibilities, such as myocardial infarction, pancreatitis or a perforated viscus. Endoscopy must be delayed until these conditions are excluded.

Upper gastrointestinal panendoscopy is considered a safe procedure with infrequent complications. These rare complications include medication reactions, aspiration pneumonia, cardiovascular sequelae and perforation of the esophagus.^{8,11} Furthermore, a certain amount of gagging and retching is unavoidable in some patients. It is not clear if this actually can aggravate bleeding from varices or mucosal tears.¹¹

As a diagnostic tool, the endoscope has taught us a great deal. It has reordered our concepts of the sources of upper gastrointestinal bleeding. Endoscopy has emphasized the importance of some bleeding sources such as erosive gastritis, esophagitis, and the Mallory-Weiss mucosal tear, which formerly were undiagnosed.¹¹ It is of particular importance in evaluating patients with multiple lesions. For example, patients with known esophageal varices have a nonvariceal source of bleeding in thirty-three to sixty percent of cases.¹⁹ The controversial issues are: Do all bleeders need endoscopy? How early should endoscopy be performed?

A very recent randomized, controlled trial concluded that endoscopy need not be a routine procedure in patients with upper gastrointestinal tract bleeding that ceases during treatment.²⁰ They found that routine emergent endoscopy did not reduce hospital deaths, recurrence of bleeding, number of transfusions or duration of hospital stay. During the twelve months after discharge, there were no significant differences in frequency of readmission, incidence of further bleeding, number of hemorrhage-related deaths or frequency of gastrointestinal surgery.

The authors of that study did not debate the importance of making a specific diagnosis in patients who continued bleeding despite usual therapy and gastric lavage. In addition, patients assigned to the "no endoscopy" group underwent endoscopy if bleeding recurred, or if the upper gastrointestinal series disclosed a gastric ulcer or suggested a malignant process. They also felt endoscopy was indicated in patients with several prior episodes of bleeding who might be candidates for elective surgery or maintenance cimetidine therapy. Furthermore, the development of endoscopic therapeutic methods, such as electrocoagulation²¹ or argon laser treatment,²² if proved useful, could demand modification of their conclusions.

In the editorial review of this study, Conn wondered if there were identifiable subgroups who may have benefited from early endoscopic examination.²³ He felt the study suggested that patients with liver disease, with recurrent hemorrhage and with persistent bleeding may benefit from early endoscopy. The failure of early endoscopy to improve prognosis could represent an example of a situation in which positive findings in a small subgroup are obscured by a large number of negative observations. Although survival was not improved by early endoscopy, one must be careful not to fault the diagnostic technique for the faults of the therapy. At the same time, we must take care that early diagnosis does not become an end in itself, and we must be cautious that attempts at early diagnosis do not prove harmful to even a minority of patients.

RECOMMENDATIONS

What then should the clinician recommend in the midst of all this controversy?

"If endoscopy fails to identify the bleeding source and the patient continues to bleed, emergency isotope scanning or angiography should be arranged."

When an upper gastrointestinal bleeder is admitted, the endoscopist on call immediately should be notified of the admission, and the patient's current status. If bleeding continues after one to two hours of lavage, endoscopy should be arranged as soon as possible. If the bleeding stops, the decision to endoscope can be delayed until the next day. We try to determine which patients are likely to rebleed and arrange to endoscope them within twenty-four hours of admission. We feel all patients with initial bleeding episodes requiring more than three units of blood should be endoscoped. We endoscope all patients who may be bleeding from esophageal varices. We also feel that patients with previous upper gastrointestinal bleeding should be endoscoped in an attempt to find lesions which might be treated better by early surgery. For example, the elderly patient with a chronic gastric ulcer is benefited by early diagnosis and surgery. Further, patients with a "visible vessel" in either a gastric or duodenal ulcer can be expected to have uncontrolled or recurrent hemorrhage and should be considered for early surgery.²⁵ If endoscopy fails to identify the bleeding source and the patient continues to bleed, emergency isotope scanning²⁶ or angiography should be arranged.²⁷ Angiography is not a simple procedure. It requires a team of highly trained personnel and the availability of an equipped x-ray room. It generally is reserved for the patient with a difficult bleeding problem which has evaded diagnosis by other means.⁴ Availability and common sense always must govern the approach: the exsanguinating patient belongs in the operating room not in a radiologic suite.

CONCLUSION

We recognize that our recommendations are based on personal experience and bias and may seem somewhat arbitrary. However, until the definitive study appears, we will continue to follow these "guidelines" while respecting the judgments and approaches of others.

REFERENCES

- Schiller KFR, Truelove SC, Williams DG: Hematemesis and melena with special reference to factors influencing the outcome. *Br Med J* 2:7-14, 1970
- Northfield TC: Factors predisposing to recurrent haemorrhage after acute gastrointestinal bleeding. *Br Med J* 1:26-28, 1971
- Allan R, Dykes P: A study of the factors influencing mortality rates from gastrointestinal hemorrhage. *Quart J Med* 45:550-553, 1976
- Protell RL, Silverstein FE, Gilbert DA, et al: Severe upper gastrointestinal bleeding. *Clin Gastroenterol* 10:17-26, 1981
- Luk GD, Bynum TE, Hendrix TR: Gastric aspiration in localization of gastrointestinal hemorrhage. *JAMA* 241:576-578, 1979
- Scott NM: Experience with the 'vigorous diagnostic approach' to upper gastrointestinal hemorrhage. *Ann Intern Med* 51:89-98, 1959
- Berkowitz D: Fatal gastrointestinal hemorrhage: Diagnostic implications from a study of 200 cases. *Am J Gastroenterol* 40:372, 1963
- Palmer ED: The vigorous diagnostic approach to upper gastrointestinal tract hemorrhage. A 23-year prospective study of 14,000 patients. *JAMA* 207:1477-1480, 1969
- Katon RM, Smith FW: Panendoscopy in the early diagnosis of acute upper gastrointestinal bleeding. *Gastroenterol* 65:728-734, 1973
- Thoeni RF, Cello JP: A critical look at the accuracy of endoscopy and double contrast radiography of the upper intestinal tract in patients with substantial UGI hemorrhage. *Radiol* 135:305-308, 1980
- Eastwood GL: Does early endoscopy benefit the patient with active upper gastrointestinal bleeding? *Gastroenterol* 72:737-739, 1977
- Morris DW, Levine GM, Soloway RD, et al: Prospective, randomized study of diagnosis and outcome in acute upper gastrointestinal bleeding: Endoscopy versus conventional radiography. *Dig Dis* 20:1103-1109, 1975
- Keller RT, Logan GM: Comparison of emergent endoscopy and upper gastrointestinal series radiography in acute upper gastrointestinal hemorrhage. *GUT* 17:180-184, 1976
- Graham DY: Limited value of early endoscopy in the management of acute upper gastrointestinal bleeding. *Am J Surg* 140:284-290, 1980
- Sandlow LJ, Becker GH, Spellberg MA, et al: A prospective, randomized study of the management of upper gastrointestinal hemorrhage. *Am J Gastroenterol* 61:282-289, 1974
- Dronfield MW, McIlmurray MB, Ferguson R, et al: A prospective, randomized study of endoscopy and radiology in acute upper gastrointestinal tract bleeding. *Lancet* i:1167-1169, 1977
- Winans CS: Emergency upper gastrointestinal endoscopy: Does haste make waste? *Dig Dis* 22:536-539, 1977
- Silvis SE, Nebel O, Rogers G, et al: Endoscopic complications: Results of the 1974 American Society for Gastrointestinal Endoscopy survey. *JAMA* 235:928-930, 1977
- Franco D, Durandy Y, Deporte A, et al: Upper gastrointestinal hemorrhage in hepatic cirrhosis: Causes and relation to hepatic failure and stress. *Lancet* i:218-220, 1977
- Peterson WL, Barnett CC, Smith HT, et al: Routine early endoscopy in upper gastrointestinal tract bleeding. *N Engl J Med* 304:925-929, 1981
- Papp JP: Endoscopic electrocoagulation of upper gastrointestinal hemorrhage. *JAMA* 236:2076-2079, 1976
- Silverstein FE, Auth DC, Rubin CE, et al: High power argon laser treatment via standard endoscopes. *Gastroenterol* 71:558-563, 1976
- Conn HO: To scope or not to scope. *N Engl J Med* 304:967-969, 1981
- Himal HS, Perrault C, Mzab R: Upper gastrointestinal hemorrhage: Aggressive management decreases mortality. *Surg* 84:448-454, 1978
- Griffiths WJ, Neumann DA, Welsh JD: The visible vessel as an indicator of uncontrolled or recurrent gastrointestinal hemorrhage. *N Engl J Med* 300:1411-1413, 1979
- Miskowiak J, Nielsen SL, Munck O, et al: Abdominal scintiphotography with 99 technetium-labelled albumin in acute gastrointestinal bleeding. *Lancet* 2:832-834, 1977
- Athanasoulis CA, Waltman AC, Novelline RA: Angiography: Its contribution to the emergency management of gastrointestinal hemorrhage. *Radiol Clin NA* 14:265-280, 1976

CASE REPORT

Listeria Monocytogenes Meningitis in an Infant of a Habitual Aborter*

JEREMIAS L. MURILLO, M.D. and
JULES A. TITELBAUM, M.D., Newark

A two-week-old infant developed *Listeria monocytogenes* meningitis. The infant's mother was an habitual aborter who carried *Listeria monocytogenes* in her cervix. The association of habitual abortion and genital listeriosis with subsequent neonatal morbidity is emphasized in this article.

The relationship between genital listeriosis, habitual abortion and perinatal infection remains unclear.¹⁻³ This report describes *Listeria meningitis* in an infant of a habitual aborter who had genital listeriosis.

CASE REPORT

A 13-day-old male infant presented with a one-day history of fever, irritability, vomiting and poor feeding. He was a 2700 gram product of a full-term, uncomplicated pregnancy delivered to a 23-year-old mother (gravida 6, para 2, abortion 4) by normal spontaneous vaginal delivery. He appeared appropriate for gestational age. The Apgar score was nine at one minute and ten at five minutes. At 24 hours of age, he developed a vesicular rash around the neck and on the lower face which later spread over the abdomen and groin. The vesicles contained clear fluid and there was no associated erythema. Gram stain of the vesicular fluid revealed no organisms and cultures taken at three different skin sites were sterile. A blood culture was also sterile. Wright stain of the vesicular fluid showed no demonstrable polymorphonuclear leucocytes or eosinophils. The vesicles disappeared on the third day of life leaving punctate pigmentations on the skin. The baby appeared asymptomatic on the fourth day and was discharged with the mother. He apparently remained well until the twelfth day of life when the presenting symptoms suddenly appeared.

On admission, he appeared irritable with a high-pitched

cry. His temperature was 101.2°, the heart rate was 130 per minute and the respiratory rate 28 per minute. His weight was 3030 grams, the length was 51 cm. and the head circumference was 34 cm. The anterior fontanelle was flat and the neck was supple. The skin was free of any rash. The rest of the examination was also unremarkable. The CBC revealed 22,700 WBC per cu. mm. with a differential count of 59% polymorphonuclears, 9% bands and 32% lymphocytes. The hemoglobin was 12.7 grams/dl and the hematocrit was 37.5 vol%. Serum electrolytes and BUN were within normal limits. A spinal tap was done and the cerebrospinal fluid (CSF) was noted to be cloudy. The CSF cell count consisted of 560 RBC per cu. mm. and 452 WBC per cu. mm. with a differential count of 55% polymorphonuclears and 45% lymphocytes. The CSF glucose was 10 mg/dl with a simultaneous blood glucose of 145 mg/dl. The CSF protein was 181 mg/dl. A gram-stained smear of the CSF revealed gram-positive rods. The CSF and blood cultures both grew *Listeria monocytogenes*. Cultures taken from the maternal cervix also grew *Listeria monocytogenes*. The baby was initially treated with penicillin and kanamycin. The organism was found to be sensitive to chloramphenicol by the Kirby-Bauer

*This report is from the New Jersey Medical School, CMDNJ and the Department of Pediatrics, Newark Beth Israel Medical Center where Drs. Murillo and Titelbaum are on the staff in the department of pediatrics and infectious diseases. Correspondence may be addressed to Dr. Murillo at the Medical Center, 201 Lyons Avenue, Newark, NJ 07112.

"... The infant acquires the infection from the mother who may carry the organism in the cervix ..."

technique. After 48 hours, kanamycin was discontinued and chloramphenicol was added to penicillin. The baby became afebrile in 72 hours. Tube dilution sensitivities were performed on the organism against chloramphenicol and revealed an MIC of 0.5 $\mu\text{g}/\text{ml}$. Chloramphenicol was used alone to complete the therapy. The baby received two weeks of intravenous chloramphenicol. He recovered completely and no neurologic abnormalities were observed upon discharge.

DISCUSSION

In 1933, Burns initially recognized the importance of *Listeria monocytogenes* as a pathogen in perinatal infection. The infant acquires the infection from the mother who may carry the organism in the cervix and may have non-specific symptomatology.¹ In addition, genital listeriosis has been suspected to cause habitual abortion.² Rappaport *et al.*³ reported positive cervical cultures for *Listeria monocytogenes* in 25 of 34 asymptomatic women with history of repeated abortions. However, Raban and David⁴ studied 74

"... it seems reasonable to investigate habitual aborters for genital listeriosis ..."

habitual aborters but could not recover *Listeria* from cervical cultures. Another study consisting of 76 habitual aborters showed similar findings.⁵

This case report illustrates an association of genital listeriosis, neonatal infection and history of habitual abortion. Because of these relationships it seems reasonable to investigate habitual aborters for genital listeriosis in order to identify high risk patients.

REFERENCES

1. Hood, M: Listeriosis as an infection of pregnancy manifested in the newborn. *Pediatr* 27:390, 1961.
2. Seeliger HPR, Cherry WB: *Human Listeriosis*. U.S. Department of Health, Education and Welfare, Public Health Service, Communicable Disease Center, Atlanta, Georgia, 1957.
3. Rappaport F, Rabinowitz M, Toaff R *et al*: Genital listeriosis as a cause of repeated abortion. *Lancet* 1:1273, 1960.
4. Raban E, David A: *Listeria monocytogenes* in abortion (letter). *Lancet* 1:228, 1963.
5. Lawler FC, Wood WS, King AE, *et al*: *Listeria monocytogenes* as a cause of fetal loss. *Am J Obstet Gynecol* 89:915, 1964.

Bulimia and Vomiting Syndrome*

ALEXANDER R. LUCAS, M.D., Rochester, MN

Numerous young women, and a lesser number of men, vomit to control their weight. Most do so only after eating excessive quantities of food and the behavior is usually secretive. This behavior is probably much more common than previously thought. Little data are available about the various behaviors which constitute the bulimia and vomiting syndrome. The condition involves episodes of excessive overeating followed by vomiting, purging or fasting. A variety of terms have been used to describe this condition, none of which is generally accepted.

DEFINITIONS

- **Anorexia nervosa**—This condition occurs ten times more frequently in females than males, usually at the time of puberty or later in adolescence.^{1,2} A behavior involving the irrational fear of becoming fat results in severe weight loss from self-starvation.
- **"Bulimarexia"**—A recent term used to describe the practice of gorging, followed by fasting, vomiting or purging.³
- **Bulimia**—An abnormal and constant craving for food; insatiable hunger or appetite. A medical term used to identify the conditions in which an individual gorges with food.
- **Binge eating**—Episodes of consuming great quantities of food—a form of bulimia.
- **"Bulimia nervosa"**—A recently proposed term to describe the irresistible urge to overeat followed by self-induced vomiting or purging.⁴
- **Functional, psychogenic or nervous vomiting**—Terms used to describe vomiting without discernible physical cause, having an assumed psychologic cause.
- **Purging**—Evacuation of the bowels with laxatives or enemas.
- **Vomiting**—Disgorging the contents of the stomach through the mouth.

Although anorexia nervosa has been written about extensively, the term is a misnomer because it does not start with a true loss of appetite. Rather, the individual with the disease actively suppresses hunger sensations. Likewise, the term "bulimarexia" (from bulimia and anorexia) is inaccurate because the condition does not manifest lack of appetite, nor is it necessarily a form of anorexia nervosa. Rather, individuals with this condition swing from overeating to emptying themselves regardless of their state of hunger or satiety. The conditions referred to as functional, psychogenic or nervous vomiting have occasionally been reported.⁵ A patient may describe this as "getting sick," with or without nausea. The reflux of ingested food has been described as occurring almost automatically or self-induced by various means. It is often assumed that the vomiting is involuntary, but close inquiry frequently reveals the intentional nature of this activity.

THE SOCIAL CONTEXT

Bulimia and vomiting have precedence in the banquets of ancient Rome. The participants, after lounging and gorging at the feast-laden tables, would tickle their throats with feathers, vomit, and return to continue overeating. In Roman times, the men engaged in this activity, while today mostly women are involved. Many clinicians speculate that "pigging out" followed by furtive vomiting has again become very widespread, this time on college campuses.

Although it is likely that both bulimia and vomiting have become common in our society, the incidence and prevalence figures are not known. Nearly half of the patients with anorexia nervosa develop bulimia and vomiting,^{4,6} but whether the behaviors represent a sequel to or a distinct subgroup of anorexia nervosa is not known.^{7,8} These behaviors clearly are not restricted to individuals with anorexia nervosa because most people who binge eat and vomit do not have anorexia nervosa. As society has placed greater emphasis on the desirability of thinness in women, it is likely that this emphasis has caused more and more individuals to vomit in order to control their weight.

The desire to become thin, more attractive, and more physically perfect can be overwhelming until vomiting becomes a daily activity and an all-consuming preference. Associated with this behavior may be the notion that if the perfect figure is attained, everything in life will be well. Some women who were highly valued as children because they excelled in so many areas found competition increasingly difficult as they reached high school and college. The expectation for women to excel in multiple areas including home and marriage, a career, and as a social and sexual being undoubtedly contributes to this condition. In certain pursuits such as dancing and gymnastics, vomiting to keep thin has become almost an occupational hazard. The extent to which men are affected is not known but some wrestlers who are required to perform at a prescribed weight resort to vomiting.

IS BULIMIA A DISEASE?

Bulimia and vomiting both are symptoms which occur in a great variety of conditions. They are not diseases. Both are behaviors which occur within a spectrum of severity and frequency. The point at which overeating becomes bulimia or when vomiting becomes abnormal is somewhat arbitrary. These symptoms may occur separately or in combination. Some overeat only, some only vomit, and some do both. Others purge as well, through the use of laxatives, enemas or

*Reprinted with permission of *Contemporary Nutrition* 6:4 (Apr) 1981, a newsletter from the Nutrition Department of General Mills, Inc., Minneapolis. Dr. Lucas is Professor in Psychiatry, Mayo Medical School, Rochester, MN 55901.

diuretics. When these activities produce physiologic symptoms and cause incapacity, the behavior should certainly be considered abnormal and pathologic.

CAUSES

There are, of course, many organic causes for vomiting such as common as well as serious illnesses.

Bulimia also can have an organic cause, such as in certain hypothalamic diseases associated with excess appetite or lack of satiety inhibition. The behaviors discussed here occur by conscious choice, particularly in regard to vomiting and purging. During episodes of extreme overeating, patients often say they feel they are driven by an irresistible force. Numerous theories have been advanced as to why certain people are prone to eating disorders. These include biologic determinants, individual psychologic and family influences and social causes.^{1-3,9} Analogy to addiction has sometimes been made in the sense that if the patient succumbs to the first bite she or he feels powerless to stop. The dilemma posed by an addiction to a substance necessary for life is apparent.

IMPLICATIONS FOR NUTRITION AND HEALTH

Frequent episodes of overeating obviously will lead to overweight and eventual obesity. By fasting, vomiting and purging, weight control may result, but weight loss and protein-calorie malnutrition may supervene. Even if the weight remains within a reasonable range, vomiting, laxative use and the use of enemas can lead to ominous medical complications, such as dehydration and electrolyte disturbances. Hypokalemia (low level of serum potassium) is the most serious of the complications and can lead to cardiovascular and kidney failure. Extensive dental enamel erosion is a result of chronic vomiting. As a rule, specific vitamin and mineral deficiencies do not develop but are possible depending on the nature of the diet and the extent of vomiting and purging. Patients with bulimia frequently have salivary gland enlargement. The mechanisms underlying this change and their significance are not clear. It is well known that women with anorexia nervosa have cessation of their menses sometimes before and always after a critical amount of weight loss. Menstrual disturbances also may occur in women with the bulimia and vomiting syndrome, particularly if there have been radical dietary changes. Other endocrine and metabolic changes are possible due to dietary aberrations, but these have not been extensively studied in anorexia nervosa.

APPROACHES TO TREATMENT

Unlike anorexia nervosa and obesity, there is no simple, foolproof treatment for bulimia and vomiting. This area is further complicated by useless treatment methods and lack of trained personnel. Initially, competent medical evaluation is of importance to assess the problem, evaluate the nutritional state of the patient, and to determine the presence of any complications. Following this, successful treatment depends on the patient to acknowledge that something is wrong, to have the motivation to overcome the abnormal behavior and exert control and willpower over the situation.

The physician and nutritionist should be aware of some general approaches to treatment. These include allowing the

patient to relate the entire story in a nonjudgmental atmosphere, followed by a frank and factual discussion of nutritional and health consequences. Personal or interpersonal conflict including anxiety, depression or social conflicts should be explored through discussion followed by appropriate psychiatric or psychologic therapy.

Treatment methods that are more specific include:

Dietary instructions—Many patients benefit from diet education as to the appropriate quantities of food necessary for weight maintenance. They have found that adherence to a set of dietary guidelines gives them a feeling of control and assurance of adequate nutrition without weight gain. Encouraging regularity in dietary habits assures weight stability and probably minimizes the likelihood of eating binges or long periods of fasting which probably also contribute to bulimia. Dietary guidelines help many patients structure and regulate their daily schedule. Careful time management seems to help avoid extremes in overactivity and boredom, which may contribute to the eating problem.

Environmental structure—When the problem is out of control, a hospital setting may be necessary. When meals are served to the patient in an established routine and snacking is avoided, many have stopped their eating binges and vomiting. This type of environmental structure has proved helpful in curtailing this problem. However, maintaining the improvement once the patient leaves the hospital and is again responsible for his own time management is more difficult.

Psychiatric treatment—When there are major disturbances in personal functioning, symptoms of severe anxiety and/or depression, psychiatric treatment is then indicated and directed toward the particular symptoms or disorder. Although there are some reports of successful psychiatric treatment for these eating disorders, in general the search for and resolution of underlying emotional or unconscious conflicts have not been effective. One theory holds that binge eating and vomiting represent inappropriate expression of anger reflecting interpersonal conflicts.⁹

Pharmacologic treatment—No drug has proved efficacy in the treatment of bulimia or self-induced vomiting. Phenytoin is reported to be effective in some individuals with bulimia.⁹

Group therapy—Group techniques have been advocated for individuals with eating disorders. One approach to the bulimia and vomiting syndrome is from the feminist perspective, conceptualizing it as a problem of female socialization.³ Methods to improve personal effectiveness and assertiveness are emphasized. Self-help groups have evolved in parts of the nation patterned somewhat along the lines of Alcoholics Anonymous.³

Other techniques—Behavior modification techniques frequently are advocated for eating disorders. These methods have appeal because of their simplicity and apparent scientific basis. However, they can be inappropriately coercive and counter-therapeutic when someone else's will is imposed upon the patient. Methods involving relaxation and biofeedback seem promising especially because they require the patient's active involvement.

SUMMARY

The bulimia and vomiting syndrome has become a widespread phenomenon and poses a major public health problem for women in their late teens, 20s and early 30s. An effective specific treatment for the condition is not yet available, but acknowledgement of the problem and the determination to overcome it are necessary for recovery.

(References available upon request.)

⁹Information about resources and support groups can be obtained from National Anorexic Aid Society, Inc., P.O. Box 29461, Columbus, OH 43229 and American Anorexia Nervosa Association, Inc., 133 Cedar Lane, Teaneck, NJ 07666.

Selected Abstracts with Comments

Wade JC et al: A comparison of trimethoprim sulfamethoxazole (TMP-SMX) plus nystatin with gentamicin (G) plus nystatin (N) in the prevention of infections in acute leukemia (AL). *N Engl J Med* 304:1057, 1981

Granulocytopenic patients with AL are at great risk of infection. TMP-SMX with or without N has been shown to be of benefit in reducing infections in such patients. This study compared TMP-SMX plus N with G plus N and found them equally efficacious but compliance was better and side effects less with TMP-SMX plus N. "TMP-SMX plus N is inexpensive and well tolerated and is an acceptable form of prophylaxis against infection during prolonged granulocytopenia."

Comment: The evidence is now compelling to use this combination in this situation. The dose in adults is one tablet to TMP-SMX (160/800 mgm) every 12 hours plus oral nystatin suspension one million units every four hours.

(R. Rapkin, M.D.)

Stamm WE et al: Treatment of the acute urethral syndrome (AUS) *N Engl J Med* 304:956, 1981

Acute dysuria and frequency in young women results usually from vaginitis, cystitis and AUS. The majority of patients with AUS have pyuria and most have lower urinary tract infection with small quantities ($<10^6$) of coliforms, staphylococci or C trachomatis. In a controlled study a tetracycline was significantly effective in treatment of pyuria associated with AUS. AUS has also been called "dysuria-pyuria" syndrome.

Comment: The physician facing a young woman with acute dysuria and frequency should check for UTI by urine culture, for vaginitis by examination and appropriate culture, and for AUS by seeking pyuria (>8 WBC per cubic millimeter of midstream urine). Lower UTI can be treated by a single dose of amoxicillin or trimethoprim sulfa; vaginitis is treated according to presumptive or proven etiology; pyuria-associated AUS best may be treated by ten days of doxycycline. The etiology of AUS without pyuria is as yet not well understood.

(R. Rapkin, M.D.)

Gerber MA et al: The child with a simple febrile seizure. *Am J Dis Child* 135:431, 1981

Review of the routine diagnostic tests performed on children with classic benign febrile seizures revealed little of diagnostic value. The authors' recommendations are: a lumbar puncture is necessary (regardless of history of previous febrile seizures) if the child is under 18 months old or there is a suspicion of meningitis; BUN, glucose, electrolytes and calcium only should be done when there is a suggestion of an underlying disorder; skull radiographs and EEGs should be

done when there is a suspicion of underlying brain disease.

Comment: The data from only 100 patients are not sufficient to be sure of these conclusions but several other studies come to the same conclusions and we should take them to heart. Except for ruling out meningitis and occult bacteremia, our response to a benign febrile convulsion (meeting the usual criteria for that diagnosis) should be benign.

(R. Rapkin, M.D.)

Greer FR et al: Bone mineral content and serum 25 hydroxyvitamin D concentration in breast-fed infants with and without supplemental vitamin D. *J Pediatr* 98:696, 1981

Should exclusively breast-fed infants receive Vitamin D? Using photon absorptiometry (bone mineral analysis can be performed in a live subject without danger), there was a significant decrease in breast-fed infants' bone mineralization when given a placebo compared to Vitamin D supplementation. The numbers are small, but these data suggest that the answer should be yes.

Reisinger KS et al: Effect of pediatricians' counseling on infant-restraint use. *Pediatr* 67:201, 1981

Taking 269 consecutive newborns, three Pittsburgh pediatricians demonstrated the effect of counseling the mothers on the importance and means of child-restraint use for safe transportation in cars. Motor vehicle crashes kill more children than any single disease and infants have the highest occupant death rate. Three separate sessions of counseling were provided for the mothers: immediately postpartum, and at the first and second month office well-child visits. The educational input included discussions on how to protect infants in cars, a pamphlet on car safety, a formal prescription for a restraint, and an actual demonstration by the pediatrician personally on the correct use of an infant restraint. A comparison control group received no such information.

Infants of the "counseled mothers" had appreciably higher use rates: 38 percent (vs 31) at one month, 50 percent (vs 29) at two months, 47 percent (vs 43) at four months, and 56 percent (vs 50) at 15 months. There was a maximal effect at two months and then a sharp drop over the next few months. Most parents continued to travel with infants held in moth-

*Abstracted from the *Department of Pediatrics Newsletter*, CMDNJ, New Jersey Medical School, Newark—Vol. 3, No. 6 (June) 1981. Selections are made by Richard H. Rapkin, M.D., Professor of Pediatrics and Medical Director of Children's Hospital, Newark, who is editor; Franklin C. Behrle, M.D., Professor and Chairman of Pediatrics; and Shyan C. Sun, M.D., Associate Professor of Pediatrics and Director, Department of Neonatology, Children's Hospital, Newark, who are coditors. Comments are prepared by them and their associates.

ers' arms, despite repeated warning about this hazard; unrestrained infants become helpless missiles in collisions, with the potential for serious injury to themselves and others within the vehicle.

Comment: The significance of this study is the demonstration that pediatric counseling, one to one, can make a difference; parents can be taught that child-restraint use is an essential responsibility for the safe transportation of their children. In a nation where no more than ten percent of the general population of car riders uses seat belts for themselves, infants and children who cannot make these decisions for themselves are in greater jeopardy. Very few pediatricians have recognized child-restraint use as an integral component of quality pediatric practice. Worse than this, in the all-too-hectic pediatric office scenario, precious few moments are available or utilized by pediatricians for direct parent counseling. This is the year that the American Academy of Pediatrics has elevated child transportation safety to top priority in its national programs. Parent educational programs on *First Ride/Safe Ride* are to be established in all maternity/newborn centers. The child who is allowed to ride unrestrained is at risk and reflects upon pediatric care as much as any child who escapes proper immunizations or health procedures. Car safety can become a tradition of good pediatrics. (S. Charles, M.D.)

Cohen C et al: Pediatric total parenteral nutrition (TPN): Liver histopathology. Arch Pathol Lab Med 105:152, 1981

This is a retrospective histologic study of autopsy liver tissue from 31 neonates given TPN with amino acid solutions or soybean oil emulsion for between one and 217 days. All except two of the neonates were premature. There was a history of sepsis in 24 patients, respiratory distress in 21, surgical procedures in 13, necrotizing enterocolitis in 12 and exchange transfusion in 10. Correlation of clinical data with hepatic histopathology in these patients suggests chronologic progression of liver disease with long-term TPN. Fatty change and a prominent eosinophil component in portal tract extramedullary hematopoiesis appear during the first five days of TPN. The former persists for 90 days, the latter for three weeks. Canalicular cholestasis was present after ten days in about 84 percent of the livers studied and bile duct proliferation in about 64 percent after three weeks TPN. Moderate to severe portal fibrosis only occurred after 90 days whereas micronodular cirrhosis developed in one patient after five months of TPN. Lipofuscin-like pigment and hemosiderin each were demonstrated in 90 percent of livers studied. The findings suggest that with up to 90 days of TPN most changes either should be reversible or not severe enough to result in liver failure.

Comment: There have been a number of reports on the liver lesions in infants given TPN. These reports describe more or less the same type of findings as seen in this study. This study, however, attempts to describe a chronological sequence of events of the pathologic changes in the liver. Although other associated factors such as sepsis, necrotizing enterocolitis, surgical complications, and others were present in some of the patients reported in this paper, their possible influence on liver pathology is not mentioned at all. This is particularly important since the pathogenesis of these lesions remains problematic. The progression of the disease with the duration of TPN as described in this paper and the return to normal liver function after discontinuation of TPN as reported in other publications (Postuma et al: *Pediatrics* 63:110, 1979) suggest that the TPN is primarily hepatotoxic.

Contributory factors such as prematurity, intercurrent infection, hepatotoxic drugs, surgical complications and exchange transfusion also have been implicated in the pathogenesis. There is only one controlled study Manginello and Javitt: *J Pediatr* 94:296, 1979) which addresses this problem. It suggests that sepsis associated with TPN is the most important factor in the pathogenesis of these liver lesions. However the last word has not yet been said on this issue.

(V.V. Joshi, M.D., Ph.D.)

Yosev R: Soft tissue infections of ampicillin resistant H influenzae type B. Am J Dis Child 135:410, 1981

Using a combination of ampicillin and nafcillin, five patients with resistant H influenzae b cellulitis were successfully treated. Synergism of ampicillin and nafcillin was demonstrated. This combination may be useful in non-meningitic resistant H influenzae infections and may reduce the need for chloramphenicol.

Biancaniello T et al: Chloramphenicol and cardiotoxicity. J Pediatr 98:828, 1981

A six-month-old infant developed acute left ventricular failure associated with a chloramphenicol level of 50 mgm/ml (toxic >30). The dose of chloramphenicol was 100 mgm/kg/day. Although not proved, cause and effect are suggested. Chloramphenicol pharmacokinetics are variable. Blood concentrations must be monitored when infants are treated with chloramphenicol.

Comment: There is no longer any choice. If you use chloramphenicol, you have to monitor it for toxicity. Laboratories must tool up. (R. Rapkin, M.D.)

Schwartz RH et al: The febrile response in acute otitis media. JAMA 245:2057, 1981

Twenty-three percent of 671 children with otitis media had fever. In only four percent did the fever last more than 48 hours after therapy had been begun. In the age group under two years, there were 41 patients and only three had fever for more than 48 hours after therapy began.

Rogers DE et al: Some observations on pediatrics. Pediatr 67:776, 1981

This address was given at the AAP meeting in October 1980. It should be read by all thoughtful physicians. Some salient points made: It is unlikely the country will spend large amounts for any new domestic health care program; hospitals and academic health centers will be financially troubled; real personal income will fall and some people may forego needed health care; we need to replace our statistical measures of medical care with better ones which measure what physicians do: restore people to fuller functioning; the pediatrician in practice will be more and more involved with school health, allergies, counseling and supervision of growth and development; pediatricians as a group should "... target very carefully on those problems which appear of most significance ... where you have evidence that your interventions really significantly can improve the lot of children ..."

(R. Rapkin, M.D.)

Hausen T et al: Lung fluid in hypoxic lambs. Pediatr Res 15:464, 1981

Term newborn lambs made hypoxic by prolonged (3 to 6 hrs) breathing of ten percent 0₂-5 percent CO₂ had lung edema. This was associated with increased pulmonary lymph flow but there was no increase in protein leakage. Thus

hypoxia caused pulmonary hypertension but did not increase pulmonary capillary permeability. Lambs delivered prematurely had hyaline membrane disease. This was associated with edematous lungs.

Comment: These experiments suggest that pulmonary edema complicates many of the pulmonary problems seen in the ICN, including hyaline membrane disease and persistent pulmonary hypertension. If extrapolation is valid, it would argue for fluid restriction and diuresis as part of early management. (O.R. Levine, M.D.)

Milstein JM et al: Pulmonary vascular response to digoxin. *Pediatr Res* 15:468, 1981

Digoxin constricts pulmonary vascular smooth muscle, raising pulmonary vascular resistance approximately 20 percent in normoxemic newborn lambs. Hypoxemic lambs were already vasoconstricted and had no further response to digoxin.

Comment: The implication is that in sick newborns with pulmonary hypertension, such as in hyaline membrane disease or in persistent fetal circulation syndrome, digitalization could increase pulmonary hypertension and right to left shunting. (O.R. Levine, M.D.)

Hunt CE et al: Abnormalities of breathing control and airway maintenance in infants and children as a cause of cor pulmonale. *Pediatr Res* 15:465, 1981

In 15 infants and children with this syndrome, four had a central defect in regulation of breathing and were treated with phrenic nerve pacing. Ten had upper airway obstruction; a few benefited from T & A, but most required tracheostomy. All had cardiomegaly and RVH.

Comment: Our own experience suggests that infants with Down's syndrome may be especially susceptible to obstructive hypoventilation. It may masquerade as cyanotic heart disease, but noisy and irregular breathing during sleep should alert one to this problem. (O.R. Levine, M.D.)

Flower R et al: Retrolental fibroplasia: Evidence for a role of the prostaglandin cascade in the pathogenesis of O₂ induced retinopathy in the newborn beagle. *Pediatr Res* 15:660, 1981

Direct ophthalmoscopic observations indicated that, whereas sustained O₂ breathing produced retinal vasoconstriction in unmedicated puppies, retinal vessels of aspirin- (anti-prostaglandin) treated littermates became more dilated or remained unchanged. Aspirin-treated puppies developed retinopathy of significantly greater severity than the unmedicated controls.

Comment: If one extrapolates this finding of the animal study to the human situation, it will make one frightened to use indomethacin for PDA in small premature. Is the recent increase in RLF due to our increasing use of indomethacin? (S. Sun, M.D.)

Frantz I et al: Improvement in pulmonary interstitial emphysema (PIE) with high-frequency ventilation. *Pediatr Res* 15:719, 1981

Five infants with severe PIE were ventilated with 480 to 720 cycles/min. All infants demonstrated prompt improvement in blood gases (PO₂ by 60; PCO₂ by 20 torr). Attempts to reinstitute conventional ventilation resulted in recurrence of PIE in two cases.

Comment: This new mode of high-frequency mechanical ventilation continues to show its promising results during the past two years. I anticipate that respirator manufacturers will

very soon come up with an attachment of this versatile high-frequency mode to their conventional ventilators.

(S. Sun, M.D.)

Kalia A et al: Idiopathic hypercalcuria (IHC) and gross hematuria (GH) in children. *Pediatr Res* 15:695, 1981

This report presents six infants and children who developed asymptomatic gross hematuria with no documented history of SS disease and no radiological findings of renal calculi or nephrocalcinosis. All patients had elevated urinary calcium. Five of the patients had family history of renal calculi. Three of the patients were treated with thiazide diuretics (which are known to reduce urinary calcium). The therapy resulted in cessation of the hematuria.

Comment: Urinary calcium measurements are not included in the routine workup of asymptomatic hematuria. Many of the patients with either chronic microscopic or gross hematuria eventually may undergo percutaneous renal biopsy. This study suggests that before subjecting these patients to such a procedure, measurements of urinary calcium are indicated to rule out hypercalcuria as the cause of the hematuria. (A. Aviv, M.D.)

Allen WR et al: Immune deposits in minimal-change nephrotic syndrome (MCNS): Clinical evidence. *Pediatr Res* 15:689, 1981

A followup of 25 children with the idiopathic nephrotic syndrome of childhood is reported. These children had the so-called "minimal change" disease. This is an histological, light-microscopy diagnosis indicating no apparent change in the glomeruli. However, all these children had either mild mesangial proliferation or some immune deposits in electronmicroscopic examinations. As compared to patients with "minimal change" disease but without immune deposits or mesangial proliferation, these children had a 16-fold increase in non-responsiveness to steroid therapy.

Comment: Children with the "minimal change" nephrotic syndrome almost always respond to steroid therapy. This entity implies excellent prognosis. The present study identifies a subcategory of this disease that does not follow the usual pattern. Some of the patients presented may be recognized later to have focal segmental glomerular sclerosis—an entity usually progressing to chronic renal failure. (A. Aviv, M.D.)

Loney LC et al: Improved technique for assessing urinary acidification. *Pediatr Res* 15:696, 1981

Oral or intravenous ammonium chloride loading has been routinely employed to evaluate the urinary acidification capacity in patients suspected to have distal renal tubular acidosis. However, this substance is tolerated poorly and when given orally, frequently produces severe abdominal pain and/or vomiting. The intravenous route is quite painful. The intravenous administration of 150-200 mMol/M²SA of arginine-HCL was demonstrated to be very effective in reducing both plasma and urinary pH, the latter to a value of 4.5-5.0 in normal patients. In contrast, receiving the same intravenous load of arginine-HCL, patients with distal renal tubular acidosis could not acidify their urine below pH 5.5. No complications or side effects were observed during and following the administration of this substance.

Comment: Arginine-HCL infusion may indeed replace ammonium chloride loading as a diagnostic procedure to identify the patient with distal renal tubular acidosis. However, the intravenous administration of this substance may occasionally produce hypoglycemia. Thus, blood glucose should be monitored during arginine-HCL loading. (A. Aviv, M.D.)

Ownership Statement

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION (Required by 39 U.S.C. 3685)

1. Title of Publication: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

1-A. Publication No.: 284740.

2. Date of Filing: September 15, 1981.

3. Frequency of Issue: Monthly.

3-B. Annual Subscription Price: \$10.00.

4. Location of Known Office of Publication: 2 Princess Road, Lawrenceville, Mercer County, New Jersey 08648.

5. Location of the Headquarters or General Business Offices of the Publishers: 2 Princess Road, Lawrenceville, Mercer County, New Jersey 08648.

6. Names and addresses of publisher, editor and managing editor: Publisher, the Medical Society of New Jersey, 2 Princess Road, Lawrenceville, N.J. 08648. Editor, Arthur Krosnick, M.D., 2 Princess Rd., Lawrenceville, N.J. 08648. Managing Editor, Mrs. Marjorie Treptow, 2 Princess Rd., Lawrenceville, N.J. 08648.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) The Medical Society of New Jersey, 2 Princess Rd., Lawrenceville, N.J. 08648. (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, and other security holders owning or holding one percent or more of total amount of bonds, mortgages or other securities: none (a non-profit corporation of New Jersey).

9. For completion by non-profit organization authorized to mail at special rates (Section 411.3, DMM only). The purpose, function, and non-profit status of this organization and the exempt status for Federal Income tax purposes have not changed during preceding 12 months.

10. Extent and nature of circulation:

	Average no. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
Extent and nature of circulation		
A. Total No. copies printed (Net Press Run)	10,689	10,300
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter sales	—	—
2. Mail subscription	10,159	9,713
C. Total Paid Circulation (Sum of 10B1 and 10B2)	10,159	9,713
D. Free Distribution by mail carrier or other means samples, complimentary, and other free copies	370	369
E. Total Distribution (Sum of C and D)	10,529	10,082
F. Copies Not Distributed		
1. Office use, left-over, unaccounted, spoiled after printing	160	218
2. Return from news agents	—	—
G. Total (Sum of E, F1 and 2—Should equal net press run shown in A)	10,689	10,300
11. I certify that the statements made by me above are correct and complete. (Signed)		

Arthur White
Director of Finance and Administrative Services

12. For completion by publishers mailing at the regular rates (Section 132.121, Postal Service Manual). 39 U.S.C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates." In accordance with the provisions of this statute, I hereby request permission to mail the publication named in item 1 at the phased postage rate presently authorized by 39 U.S.C. 3626 (Signed)

DOCTORS' NOTEBOOK

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

I am pleased this month to announce the inauguration of an exciting new venture in health care, established under the direction of CMDNJ and one of its major affiliates.

With the approval of the New Jersey Department of Health, the Statewide Perinatal Services and Research Center has been established in Newark. Operated jointly by the CMDNJ-College Hospital and Children's Hospital of the United Hospitals Medical Center, the new facility utilizes the resources of both institutions in obstetrics and pediatrics to create a comprehensive program in neonatology and perinatology which far exceeds the requirements for Perinatal III designation.

The new center, which is designed to serve as a resource for the entire State, consolidates all aspects of the health sciences which deal with pregnant women and infants. It offers the broadest range of health services available in New Jersey, supported by the most sophisticated technology for diagnosis and treatment and the professional expertise of a wide variety of tertiary care specialists. In addition, it provides a full spectrum of educational programs in aspects of maternal and fetal medicine and serves as a base of an active, diversified research program.

We hope to see this center develop as the hub of a network which ties together all of New Jersey's perinatal facilities. Practitioners throughout the State can make use of its resources by means of a 24-hour "hot line" service, by which they can obtain advice on patient management or arrange for patient transfer. The facility is served by the Regional Emergency Medical Communications System, which is equipped with specially designed vehicles for the transportation of higher-risk patients and newborns. In addition, helicopter transport can be arranged through the New Jersey State Police, so that no New Jersey patient is

more than 30 to 40 minutes away from the center.

The center also has New Jersey's only 24-hour "on-call" Neonatal Resuscitation Team, which is available to any community hospital on request. Other unique services offered by the joint program include: a genetics laboratory for the diagnosis of hereditary diseases; an endocrine laboratory, equipped to perform the most difficult hormonal assays on pregnant women; the State's only blood coagulation laboratory and its most advanced ultrasound diagnostic laboratory.

Related services which support the center are a pediatric cardiac diagnostic and treatment center, which provides the most advanced diagnostic and surgical techniques for even the smallest newborns, and a neurosurgical center to provide expertise for the management of difficult neonatal problems such as hydrocephalus and meningomyelocele. It also provides ready access to experts in subspecialty fields such as hepatology and nutrition, pediatric ophthalmology, pediatric pathology, child psychiatry, pediatric and obstetrical anesthesiology, pediatric radiology and pediatric urology.

In education, the center serves as a training site for CMDNJ's medical, postgraduate and nurse midwifery students, as well as for nursing students for the Rutgers School of Nursing and nurses in the Pediatric Nurse Practitioner Program offered by Seton Hall University. In addition, it sponsors a wide variety of continuing education programs for physicians, nurses and allied health professionals, as well as an extensive program in consumer health education.

Because of the number of high-risk cases it handles and the extensive research facilities available through the medical school's departments of pediatrics and obstetrics and gynecology, the center is also in an advantageous position to foster clinical research. Some 30 studies are currently underway, dealing with clinical problems in perinatology and neonatology.

I should point out that the center is not "new" in the sense that it required any additional construction, equipment purchases or personnel. Both CMDNJ and United Hospitals have been developing excellent perinatal programs over the past decade, and both are fully qualified for Perinatal III designation. The sophisticated equipment and specialized personnel which make this program unique in the State are already in place, in keeping with the needs of a health science university.

In addition, the cooperative efforts between the two institutions are firmly established, and were formalized two years ago when CMDNJ-College Hospital assumed all of the obstetrics cases for both institutions and United took over most of the pediatrics services. Extensive consolidation efforts already have taken place, eliminating the need to duplicate costly equipment and personnel, and a pattern of ready transfer between the two hospitals is firmly in place.

Indeed, the center's health care programs are so well established that its plan for future innovation are primarily in expanding its educational offerings. A program of "mini-residencies" for pediatricians focusing on the management of the critically ill newborn is in development, as is a newborn-resuscitation course for obstetricians, pediatricians and perinatal nurses. Plans are also underway for masters-level programs for nurse specialists in both perinatal and neonatal services.

But I believe that the most significant aspect of this new designation is that it formally establishes the center as a statewide resource, enhancing its efforts toward service to hospitals throughout New Jersey. The center currently receives about 400 referrals a year from some 50 hospitals. Most of these cases now are coming from nearby facilities in Essex, Union and Hudson counties, but we have begun to receive patients from more distant parts of the State, including Warren, Sussex, Bergen and Passaic counties, as well as Middlesex and Atlantic.

We hope that our resources soon will

be utilized on a regular basis by professionals in every part of the State. As an integral part of New Jersey's State Perinatal Plan, the Center is a key element in our State's efforts to reduce maternal and infant morbidity and mortality. Obviously, not every community hospital can afford to support expensive equipment and personnel, but through cooperative efforts, such as this State-wide Perinatal Services and Research Center, every New Jerseyan can have access to "state of the art" health care.

MSNJ Auxiliary

**Phyllis Romano
President**

We, the Medical Auxiliaries, are no longer a tea and cookie organization. We are your most undeveloped resource—your strongest ally—and your greatest advocate.

We are active in health education; conduct shape-up for life programs, nutrition and health education fairs; engage in weight reduction seminars and drug education; aid in crediting nursing education; sponsor hypertension, sight, hearing and immunization programs; advocate and sponsor cancer detection programs; promote the concept of breast self-examination; support medical student loan funds, and the AMA Education and Research Foundation.

We can and must do more. We can help in dealing with the many issues facing organized medicine in New Jersey today. There is an adverse effect and a very high cost of governmental regulations in the delivery of health care. We should make the public aware that in Great Britain, 85 percent of the cost of health care delivery under National Health Insurance is expanded in non-medical areas. We need to make the public aware of the drug abuse problems and convince the government, the media industry, everyone of the urgency of the problem and the need for solutions.

The Medical Society of New Jersey's Long Range Planning and Development Committee developed guidelines for the enlarged role of the Auxiliary in Medical Society affairs and the Board of Trustees adopted the following recommendations:

1. Appointment of auxiliary members to administrative councils and committees.
2. Invited to attend Board meetings, councils and committee meetings.
3. Increased involvement in legislative and political action.

4. Increase the auxiliary's role in county medical societies.

5. Assist in research projects.

6. Publish articles in *The Journal* and other publications.

7. Establish direct liaison with hospital auxiliaries.

We can act as lobbying agents with legislators and also as your lobbyist through JEMPAC—to present your views and your needs. We can act as your representatives at HSAs and other agencies that infringe on your practice—we must protect our collective interest. We want to help you improve your public relations image by engaging in good works and making the media aware of it.

We must publicize to all spouses of physicians that their future is intimately tied up with yours, and we must have them join us before it is too late. Whatever affects you and your practice of good quality health care will also affect us. We must become knowledgeable in all facets of your profession—that which is conducive to the practice of good quality health care and that which threatens it either by the bureaucracy, governmental regulations, and so on. Only by attending your Executive Committee meetings and council and committee meetings can we hope to accomplish this phase and also successfully fulfill the tasks before us.

We are not desirous of infringing on the business of your society. We want to help you—our spouses—by relieving you of those tasks not pertaining to medicine and performing them ourselves.

Dr. Armando Goracci, President of the Medical Society, has appointed Auxiliaries to twelve State councils and/or committees, and for the past several years, the President of the State Auxiliary has been attending the MSNJ Board of Trustees' meetings. There are several county medical societies who have requested a representative from their auxiliary to attend their Executive Committee meetings, and are also in the process of making appointments to their various councils and committees. We are hopeful that all county medical societies will follow the State guidelines.

We believe that the medical profession's survival does depend on its actions rather than its reactions. Your future is our future. As partners, we shall and must accomplish more. We shall implement all of the recommendations approved by the MSNJ Board of Trustees and to that end we need each other.

Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY/IMMUNOLOGY—Leonard Cohen, M.D., 7545 York Drive, Clayton, MO 63105. New York University 1977. Also general internal medicine. Board certified (IM). Board eligible. Multi-specialty group, partnership, solo, academic. Available July 1982.

ANESTHESIOLOGY—Hossain Esmaili, M.D., P.O. Box 1017, Franklin, VA 23851. Tabriz (Iran) 1971. Any type practice. Available.

CARDIOLOGY—Raj D. Savajiyani, M.D., 3807 North 30th Street, Apt. 25, Phoenix, AZ 85016. Baroda (India) 1975. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1982.

Anil Rastogi, M.D., 1350 West Bethune, Apt. 1502, Detroit, MI 48202. Rajasthan (India) 1974. Also, general internal medicine. Board certified (IM). Cardiac catheterization—group, partnership, solo. Available July 1982.

Mark Leberthal, M.D., 1164-4 Bibbs Road, Voorhees, NJ 08043. SUNY-Stonybrook 1977. Board eligible. Group or partnership—cardiology or cardiology/internal medicine. Available July 1982.

Stephen Rothbart, M.D., 1343 Amherst Avenue, Union, NJ 07083. CMDNJ 1977. Trained in all invasive and non-invasive techniques. Group, partnership, solo. Available July 1982.

Arkady B. Rapoport, M.D., 4121 Meadowbrook Lane, Minneapolis, MN 55426. Minnesota 1981. Also, general internal medicine. Board eligible (both IM and cardiology). Group, partnership, solo. Available July 1982.

Richard C. Redline, M.D., 26 Mt. Vernon Street, Apt. 4-F, Boston, MA 02108. Virginia 1977. Also, general internal medicine. Board certified (IM). All areas of cardiology including echocardiography, nuclear, catheterization. Group, partnership, solo. Available July 1982.

EMERGENCY ROOM—Pramila M. Umaphathi, M.D., P.O. Box 1108, 27 Eagle Avenue, Apt. B, North Park, Wheeling, WV 26003. Madras (India) 1971. Also, family practice and obstetrics/gynecology. Group practice or hospital emergency room. Available.

FAMILY MEDICINE—Catherine M. Sharkness, M.D., 6 Dartmouth Avenue, Apt. 2-A, Bridgewater, NJ 08807. Medical College of PA 1979. Board eligible. Group, partnership. Available August 1982.

Lisa Nierenberg, M.D., Somerset Family Practice, Rehli Avenue, Somerville, NJ 08876. Penn State 1979. Board eligible. Group (small). Available August 1982.

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule contains:

Pentylentetrazole	..... 100 mg.
Nicotinic Acid	..... 100 mg.
Ascorbic Acid	..... 100 mg.
Thiamine HCL	..... 25 mg.
L-Glutamic Acid	..... 50 mg.
Niacinamide	..... 5 mg.
Riboflavin	..... 2 mg.
Pyridoxine HCL	..... 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Pramila M. Umapathi, M.D., P.O. Box 1108, 27 Eagle Avenue, Apt. B, North park, Wheeling, WV 26003. Madras (India) 1971. Also, emergency room and obstetrics/gynecology. Group practice or hospital emergency room. Available.

GASTROENTEROLOGY—Yong Wun Chung, M.D., 3937 Lankenau Avenue, Philadelphia, PA 19131. Chonnam (Korea) 1972. Also, general internal medicine. Board certified (IM). Group, partnership, solo. Available July 1982.

Philip Nagel, M.D., 8155 North Karlov, Skokie, IL 60076. University of Pennsylvania 1974. Also, general internal medicine. Board certified (IM). Consultative gastroenterology—single or multi-specialty group, clinic or hospital-based practice. Available July 1982.

GENERAL MEDICINE—Biagio Scialpi, M.D., 330 Park Hill Avenue, Yonkers, NY 10705. Bari (Italy) 1949. Group, solo, or full-time position in industry or insurance. Available.

HEMATOLOGY/ONCOLOGY—Michael Willen, M.D., 164 Homestead Avenue, Albany, NY 12203. New York Medical 1976. Also, general internal medicine. Board certified (IM). Board eligible—hematology/oncology. Group or partnership. Available July 1982.

INDUSTRIAL MEDICINE—Albert Abraham, M.D., 11 Cromwell Drive, Convent Station, NJ 07961. New York University. Board certified (IM). Medical directorship (preferably in or near Morris County). Available.

INTERNAL MEDICINE—Ruth C. Wang-Liang, M.D., 68 Colfax Road, Wayne, NJ 07470. Temple 1978. Board eligible. Group, HMO. Available.

Anthony A. Losardo, M.D., 1545 East 5th Street, Brooklyn, NY 11230. Einstein 1977. Subspecialty, cardiology. Board certified. Group or partnership. Available July 1982.

Alan Greenwald, M.D., 51-D Wedgewood Drive, Stratford, CT 06497. Chicago Medical 1976. Subspecialty, gastroenterology. Board certified. Board eligible (gastroenterology). Group, partnership, or multi-specialty group. Available July 1982.

Chaitanya S. Kadakia, M.D., Covered Bridge Terrace, Apt. D-2, Philippi, WV 26416. M.S. University (India) 1976. Board certified. Solo, associate, group. Available July 1982.

Neil H. Caplan, M.D., 27 West Penn Street, Long Beach, NY 11561. Bowman-Gray 1965. Board eligible. Outpatient (health service, clinic or other)—preferably in northern NJ. Available.

Herbert F. Rest, M.D., 2 Belmont Avenue, Brattleboro, VT 03501. Hahnemann 1965. Group. Available December 1981.

Jay I. Lipoff, M.D., 214 East Spooner Road, Milwaukee, WI 53217. NYU. Subspecialty, cardiology. Board certified. Group or solo. Available January 1982.

Bakhti J. Sinor, M.D., VA Medical Center, Dept. of Medicine, Northport, NY 11768. Seth G.S. (India) 1973. Subspecialty, hematology/oncology. Board certified

(hematology). Group, partnership in oncology/hematology. Available.

Jonathan R. Anolik, M.D., 6107 Breezewood Court, #203, Greenbelt, MD 20770. Loyola/Stritch 1977. Subspecialty, endocrinology. Board certified. Group or partnership. Available July 1982.

Jerome S. Fischer, M.D., 1400 South Joyce Street, Arlington, Va 22202. Jefferson 1977. Subspecialty, endocrinology. Board certified. Group or partnership. Available July 1982.

T.M. Gupta, M.D., 8093-202 Valcour Avenue, St. Louis, MO 63123. Osmania (India). Subspecialty, cardiology. Board eligible. Solo, group, partnership (trained in all aspects of invasive/non-invasive cardiology). Available July 1982.

Harold S. Wilkes, M.D., 350 East 17th Street, Apt. 9-D, New York, NY 10003. New York Medical 1977. Subspecialty, cardiology. Board certified. Group, partnership. Available July 1982.

David Guttman, M.D., 353 East 17th Street, New York, NY 10003. New York University 1977. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available July 1982.

Cuddalore P. Vasudevan, M.D., 14500 S. McNab Avenue, Apt. 2810, Bellflower, CA 90706. Madras 1974. Subspecialty, pulmonary medicine. Board certified. Solo. Available July 1982.

James A. Scerbo, M.D., 3582 Green Brier Boulevard, Apt. 404-C, Ann Arbor, MI 48105. Columbia 1979. Partnership or group. Available July 1982.

Arvind M. Mehta, M.D., 672 General Scott Road, King of Prussia, PA 19406. Baroda (India) 1973. Subspecialty, cardiology (preferably noninvasive). Board eligible (both). Single or multi-specialty group. Available.

NUCLEAR MEDICINE—Maria I. Straub, M.D., 254 Frances Street, Teaneck, NJ 07666. University of Budapest (Hungary) 1967. Special interest, diagnostic radiology. Board eligible. Available.

OBSTETRICS/GYNECOLOGY—Tsu Ming Chu, M.D., 269-19 80th Avenue, New Hyde Park, NY 11040. Kaohsiung Medical (Taiwan) 1972. Board eligible. Partnership, group, fellowship, full-time institute. Available.

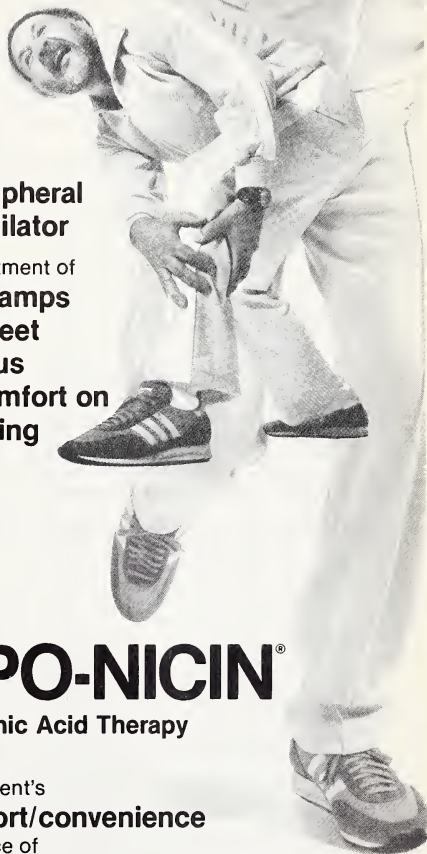
Myles E. Dotto, M.D., 44 Lyndhurst Avenue, Providence, RI 02908. CMDNJ 1975. Board eligible. Group, partnership, solo. Available July 1982.

Gary K. Schneider, M.D., 145 East 27th Street, Apt. 5-B, New York, NY 10016. SUNY-Downstate 1978. Board eligible. Group, partnership, or academic. Available July 1982.

Pramila M. Umapathi, M.D., P.O. Box 1108, 27 Eagle Avenue, Apt. B, North Park, Wheeling, WV 26003. Madras (India) 1971. Also, emergency room or family practice. Group or hospital emergency room. Available.

A peripheral vasodilator

for treatment of
**leg cramps
cold feet
tinnitus
discomfort on
standing**



LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg
Ascorbic Acid 150 mg
Thiamine HCL (B-1) 25 mg
Riboflavin (B-2) 2 mg
Pyridoxine HCL (B-6) 10 mg
in a special base of prolonged therapeutic effect.

DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg
Niacinamide 75 mg
Ascorbic Acid 150 mg
Thiamine HCL (B-1) 25 mg
Riboflavin (B-2) 2 mg
Pyridoxine HCL (B-6) 10 mg
DOSE: 1 to 3 tablets daily

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg
Niacinamide 75 mg
Ascorbic Acid 150 mg
Thiamine HCL (B-1) 25 mg
Riboflavin (B-2) 2 mg
Pyridoxine HCL (B-6) 10 mg
DOSE: 1 to 5 tablets daily

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg or 250 mg is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



OPHTHALMOLOGY—Charles D. Howard, M.D., 2605 Stearns Hill Road, Waltham, MA 02154. Guadalajara (Mexico) 1976. Special interest, corneal or external diseases. Solo, partnership, single-specialty group. Available July 1982.

ORTHOPEDICS—Cary Ian Skolnick, M.D., 2250 North Circle Drive, Ann Arbor, MI 48103. Creighton 1977. Partnership, group. Available July 1982.

OTOLARYNGOLOGY—Donald V. Wilson, M.D., 20 Lahiki Circle, Aiea, Hawaii 96701. Temple 1975. Board certified. Group, partnership, will consider solo. Available August 1982.

PATHOLOGY—Anna Kumar, M.D., 6223-B Newport Avenue, Norfolk, VA 23505. J.L.N. Medical (India) 1972. Board eligible (AP/CP). Group, solo, or partnership. Available.

Daniel Williams, Jr., M.D., 77 Rippowam Road, Apt. A, Stamford, CT 06902. Vanderbilt 1975. Special interest—clinical pathology and blood banking. Board certified. Any type practice. Available.

PEDIATRICS—Susheela Raghunathan, M.D., 9 Weston Place, East Brunswick, NJ 08816. India 1973. Board eligible. Group, institutional, clinic, emergency room, or house staff, student health center. Available.

Bernard Samtoy, M.D., 4040 Marshall Avenue, Lorain, OH 44053. Montpellier (France) 1974. Subspecialty, pediatric nephrology. Board certified. Group or partnership. Available.

Richard Dicker, M.D., 23 Park Avenue, Caldwell, NJ 07006. Guadalajara (Mexico) 1978. Group or partnership. Available July 1982.

PHYSIATRY—Lisa Bhansali, M.D., 49 Hamilton Lane South, Plainsboro, NJ 08536. LTM Medical College (India) 1972. Board eligible. Group, clinic, or as staff. Available.

PHYSIATRY—Paul L. Maithey, M.D., 99 Pawnee Road, Lakewood, NJ 08701. University of Graz (Austria) 1951. Board eligible. Available.

PULMONARY DISEASES—Paul M. Friedman, M.D., 1303 York Avenue, New York, NY 10021, SUNY-Downstate 1977. Board certified (IM). Group or partnership. Available July 1982.

Surinder K. Aneja, M.D., 90A Garden Village Drive, Apt #4, Cheektowaga, NY 14227. Punjab (India) 1974. Also, general

internal medicine. Board certified (IM). Group or solo. Available July 1982.

Somnath N. Naik, M.S., 288 Bay 38 Street, Apt. 5-U, Brooklyn, NY 11214. Seth G.S. (India) 1976. Also, general internal medicine. Board certified (IM). Any type practice. Available July 1982.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379, Shah (India) 1969. General practice and rehabilitation medicine. Available on three months' notice.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available.

Thomas A. Giangrosso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available.

SURGERY, GENERAL—S.R. Bajina, M.D., E1501, Park Towne Place, 2200 Benjamin Franklin Parkway, Philadelphia, PA 19130. Special interest—gastrointestinal endoscopy. Board certified. Solo, group, institutional-based. Available.

Rajendra M. Agarwal, M.D., 318 East 15th Street, New York, NY 10003. King George's (India) 1968. Solo, group, or partnership. Available.

P. Joshua Mammen, M.D., 404 West 51st Street, Apt. 2-B, New York, NY 10019. Trivandrum (India) 1970. Board eligible. Group, partnership, solo. Available.

B. Paulauskas, M.D., Route 1, Box 273-M, Lake Placid, FL 33852. Lithuania 1972. Special interest, vascular surgery. Board eligible. Group, partnership, solo. Available.

Kong Hua L. Go, M.D., 605 Louisiana Avenue, Apt. 17-A, Brooklyn, NY 11239. Far Eastern (Philippines) 1973. Board eligible. Any type practice. Available.

Job S. Kakkaseril, M.D., 3194 McGill Lane, Cincinnati, OH 45239. Pradesh (India) 1972. Board eligible. Group, solo, or partnership. Available.

M.S. Bose, M.D., Box 847, Mullens, WV 25882. Andhra (India) 1970. Board certified. Any type practice. Available.

Ahmed I. Khan, M.D., 5627 North 16th Street, Apt. H-8, Phoenix, AZ 85016. Dacca (Bangladesh) 1972. Also, peripheral vascular surgery. Any type practice. Available.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available.

Inder J. Singh, M.D., WCMC #1C Beachwood Hall, Valhalla, NY 10595. K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available.

SURGERY, PLASTIC—Vasdev S. Rai, M.D., 435 East 70th Street, Apt. 22-B, New York, NY 10021. Punjab (India) 1973. Board eligible. Solo, partnership, group. Available July 1982.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969. Board certified. Solo, group, associate. Available.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available.

Ahmed I. Khan, M.D., 5627 North 16th Street, Apt. H-8, Phoenix, AZ 85016. Dacca (Bangladesh) 1972. Also, general surgery. Any type practice. Available.

UROLOGY—Talluri Balaji, M.D., 1926 West Harrison St., Apt. 916, Chicago, IL 60612. Osmania (India) 1973. Solo. Available July 1982.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available.

Mahendra S. Shah, M.D., 62 Forsythia Lane, Paramus, NJ 07652. Baroda (India) 1968. Board certified. Group or partnership. Available.

Tahmoures Furoozi, M.D., 3646 Tuscola Avenue, Seaford, NY 11783. Esfahan University (Iran) 1966. Board eligible. Any type practice. Available.

Albert E. Kaufman, M.D., 2020 Forestdale Drive, Silver Spring, MD 20903. Ghent (Belgium) 1974. Board certified. Group, partnership. Available.

Dilip R. Patel, M.D., 483 Ocean Parkway, Apt. 4-B, Brooklyn, NY 11218. Baroda (India) 1973. Board eligible. Any type practice. Available.

LETTER TO THE JOURNAL

Seizures and Sports

August 27, 1981

Dear Sir:

The informative and timely contribution by Hirsch, *et al.*, "Pre-participation Evaluation for School Athletic Programs" (*J Med Soc NJ* 78:585-590, 1981), focuses on many important issues regarding restrictions upon school athletes with specific medical conditions. School children with epilepsy are faced with a number of considerations that I would like to discuss in further detail.

As a neurologist, the guiding principles which I employ and recommendations about sports participation for the *well-controlled* epileptic are as follows:

1. The individual should avoid situations in which a sudden loss of consciousness will result in serious bodily harm, e.g., skiing, trampoline, uneven parallel bars, weight lifting, rope climbing.

2. The effect upon the athlete, if a recurrence of seizure necessitates a period of increased restrictions until it is safe to resume a full program. The physician needs to have some feeling as to how heavily invested emotionally the athlete becomes in his sport and how well the

person, often an adolescent, will be able to handle a more restricted routine if the situation arises. This issue is best raised early in the course of treatment to avoid an emotional shock with an angry response when first presented at the time of seizure recurrence. I consider it an important part of the initial therapeutic contract between doctor and patient (and parents). Further, this consideration increases the athlete's motivation to take medication faithfully, obtain blood levels when necessary, and observe cautions regarding regular hours, alcohol and illicit drugs.

3. The individual and the parents must be aware that with participation in any sport, there is some small risk of injury from seizures above the risks in a child who does not have epilepsy. They can be reassured that for baseball, football, soccer, and basketball, the danger is small, but they must accept a small increased chance of injury in order to allow the child to participate.

In view of the above, here is my approach to restriction on organized athletics:

Swimming—Only with close observation by an individual who is aware that the athlete has had a seizure or "passed out"

in the past and would be able to assist if necessary.

Diving—No board above three feet.

Weight Lifting—Only with an informed buddy system, as in swimming (see above).

Jogging and Track—No jogging in the street or alone into uninhabited areas (woods, empty beach).

Skiing, Trampoline, Uneven Parallel Bars, Mountain Climbing, Solitary Hiking, Rope Climbing, Water Skiing—Not permitted.

This list does not mean that such activities are denied at all times, i.e., that an individual with epilepsy cannot go skiing or jog home from school. The concern about safety enters when the athlete is involved in a regular intensive program with repeated exposure as in organized athletics.

The forthright courage of professional athletes with epilepsy making their condition known to the public has given a psychological boost to many young aspirants—All-American and professional all-star Bobby Jones of the Philadelphia 76-ers and Gary Howatt, professional hockey player.

(signed) Damon M. Fellman, M.D.

LETTERS OF INTEREST

Bygone Practice in North Africa

August 16, 1981

Dear Dr. Calo:

I just thought I ought to drop you a note of appreciation for your fascinating and well-done article "Notes on a Bygone Practice in a North African Country," which appeared in the August, 1981 issue of *The Journal* of the Medical Society of New Jersey (78:606-610). It was pointed out to me by my wife, Christine Haycock, M.D., who has a practice in general surgery. We had been watching an installment of the British television series "The Search for the Source of the Nile," and Richard Burton (who translated *A Thousand and One Arabian Nights*) had just had a coronary and a doctor was rushed in with a box and I asked my wife if they had invented the electrocardiograph at that time (before World War I), and she thought they had a very large, clumsy machine, operated by batteries as early as the 1890s.

She probably showed me the piece because you mention two older models of the electrocardiograph and possibly the older one was around at the turn of the century. While that may have been her reason for giving me the article, I found the entire thing absorbing and must say that you are a good writer as well as a good doctor.

I also found particularly interesting that you attached more importance to stress than to diet in the incidence of coronary disease. While most doctors writing on the subject unqualifiedly cite it as a major factor, particularly in bringing on high blood pressure, which in turn can lead to heart disease, the vogue in recent times seems to be to make diet the primary culprit (though cigarettes are gaining ground). It makes it difficult for the laymen to take preventive action. It reminds me of my old "science classes" in grade school, where they did warn us constantly (almost 55 years ago) that smoking was bad, as was alcohol, coffee, too much meat, salad dressing and eventually sex, but they filled me

with despair when one lecturer told us about the number of varieties of germs we inhaled with every breath. They could offer no precautionary method of preventing this.

Just a note of appreciation for a very interesting piece.

(signed) Sam Moskowitz

August 24, 1981

Dear Dr. Calo:

Your article entitled, "Notes on a Bygone Practice in a North African Country" which recently appeared in *The Journal* of the Medical Society of New Jersey (78:606-610, August 1981) was fascinating. The medical, political, religious and historical aspects of your life and practice in Tunis are described in a most interesting way.

During the Second World War, I was stationed for a time in Algeria, in the vicinity of Oran and your descriptions brought back many memories.

(signed) Jules H. Bromberg, M.D.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physician Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Jan.

- 19 **Dinner Meeting**
7:45-8:45 p.m.—Ramada Inn, Clark
(*NJ State Society of Anesthesiologists and AMNJ*)

CARDIOLOGY

Dec.

- 2 **Cardiology Conference**
3:30-5:30 p.m.—Middlesex General Hospital, New Brunswick
(*Rutgers Medical School, Somerset County Heart Association and AMNJ*)
- 4 **Cardiomyopathy**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 10 **Cardiac Arrhythmias**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)

Jan.

- 13 **Risk Factors in Heart Disease**
- 27 **Is Atherosclerosis Reversible?**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Dec.

- 1 **Diabetes Update**
- 8 **Infection in Compromise Host**
8-9 a.m.—Greater Paterson General Hospital
(*Greater Paterson General Hospital and AMNJ*)
- 1 **Platelet and Leukocyte Therapy**
3-6 p.m.—Rutgers Medical School, Piscataway
(*New Jersey Blood Services and AMNJ*)
- 2 **Topic to be announced**
1-5 p.m.—Somerset Medical Center, Somerville
(*NJ Society for Gastrointestinal Endoscopy, Somerset Medical Center and AMNJ*)
- 2 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
- 2 **Arthroscopy**
11:30 a.m.-12:30 p.m.—Columbus Hospital, Newark
(*Columbus Hospital and AMNJ*)
- 2 **Allergies for the Primary Care Physician**
1:30-2:30 p.m.—Rutgers Community Health Plan, New Brunswick
(*Rutgers Community Health Plan and AMNJ*)
- 2 **Monthly Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section of AMNJ*)
- 2 **Vitamins—Facts and Fictions**
- 16 **Scientific Basis for Control of Environmental Diseases**
9:30-11:30 a.m.—Dover General Hospital
(*Dover General Hospital and AMNJ*)
- 2 **Sleep, Circadian Rhythm and Cardiovascular Disease**
- 9 **Pitfalls and Problems of Measuring Blood Pressure**
- 16 **Osteoporosis and Osteomalacia**
9:30-11 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 2 **Acute and Chronic Kidney Failure**
- 9 **Update of Esophageal Disorders**
- 16 **Nuclear Medicine and the Kidney**
- 23 **Diabetes: Problems of Hypoglycemia**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 2 **Endocrine Conferences**
- 9 **3:30-5 p.m.—Rotates between Newark Beth Israel Medical Center, College Hospital, Newark and VA Medical Center, East Orange**
(*Endocrinology Section of AMNJ*)
- 3 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(*Endocrinology Section of AMNJ*)
- 3 **Hypoglycemia**
12 noon-1 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 3 **Skin and Connective Tissue**
- 10 **Excretory System**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)
- 4 **Medical Grand Rounds**
11:30 a.m.—College Hospital, Newark
(*Endocrinology Section of AMNJ*)
- 4 **Pulmonary Emboli**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 4 **The Challenge of Cancer**
9:45 a.m.-3:45 p.m.—Rutgers Medical School, Piscataway
(*Larry Schneider Memorial Fund, Community Mental Health Center of*

Rutgers Medical School, Graduate School of Social Work and AMNJ)

- 4 **Renal Conferences in Nephrology**
- 18 **4-5 p.m.—College Hospital, Newark**
(*Nephrology Society of NJ and AMNJ*)
- 8 **Proper Use of Endoscopy**
8 p.m.—Burdette Tomlin Memorial Hospital, Cape May Courthouse
(*AMNJ*)
- 9 **Laboratory Findings in Adolescents**
9 a.m.—Freehold Area Hospital
(*AMNJ*)
- 9 **Portal Hypertension**
- 16 **Glomerular Disease of the Kidney**
1-2:30 p.m.—Christ Hospital, Jersey City
(*AMNJ*)
- 11 **Vasculitis**
8:30-9:30 a.m.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)
- 15 **Diseases of the Esophagus**
12 noon-1 p.m.—St. Mary's Hospital, Orange
(*AMNJ*)
- 15 **Urology**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 15 **Acute Bowel Infarction**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 16 **Nosocomial Infection**
9 a.m.-1 p.m.—Saint Michael's Medical Center, Newark
(*Saint Michael's Medical Center and AMNJ*)
- 17 **Sexual Reeducation and Counseling of Spinal Cord Injury Patients**
1-2:30 p.m.—VA Medical Center, East Orange
(*VA Medical Center and AMNJ*)
- 21 **Disorders of the Esophagus**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)

Jan.

- 5 **Thyroid Diseases**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 6 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
- 6 **Immunology (Clinical)**
11:30 a.m.—Columbus Hospital, Newark
(*AMNJ*)
- 6 **Proper Use of Endoscopy**
1 p.m.—Christ Hospital, Jersey City
(*AMNJ*)
- 6 **Dinner Meeting**



LIKOFF CARDIOVASCULAR INSTITUTE
of Hahnemann Medical College & Hospital

CARDIOLOGY UPDATE . . .

is designed for the Internist/Cardiologist, which provides an intensive survey of the current status of Clinical Cardiology . . .

**Wednesday,
December 2, 1981**

*20 Minute Lectures—Questions
and Answers (10 minutes)*

MODERATOR: Bernard L. Segal, M.D.

THE DIAGNOSIS OF PROSTHETIC VALVE
MALFUNCTION: CASE PRESENTATION

Gary S. Mintz, M.D.

EVALUATION OF PATIENTS WITH CORONARY
HEART DISEASE—RADIONUCLIDE IMAGING:
CASE PRESENTATION

Abdulmassih S. Iskandrian, M.D.

OLD AND NEW BETA-BLOCKING AGENTS—AD-
VANTAGES AND DISADVANTAGES

David T. Lowenthal, M.D.

THE CHOLESTEROL DEBATE: WHAT ARE THE
FACTS?

Sheldon R. Bender, M.D.

CASE PRESENTATION: DISCUSSION

Stanley Spitzer, M.D.

3:00 PM—2nd floor New College Building,
Hahnemann
Medical College and Hospital

• NO REGISTRATION FEE • NO ADVANCE
REGISTRATION REQUIRED • CME
CATEGORY 1 CREDITS CERTIFIED • WINE &
CHEESE SERVED AT 5:30 P.M. •

COLLECTION SERVICES

FEES:

- (1) Collection from first letter only - -
10 % of amount collected (min. \$30 fee)
- (2) Collection from further contact - -
28% of amount collected (min. \$30 fee)

References	David B. Watner	(201)
Available	Attorney at Law	736-8862
Upon	P.O. Box 94	
Request	Short Hills, N.J. 07078	

Course Title: DERMATOLOGY AND INTERNAL
MEDICINE, New Advances in
Diagnosis and Management

Course Dates: February 12-14, 1982

Course Site: The Homestead, Hot Springs, Virginia

Sponsor: Medical College of Virginia

Guest Lecturer: Thomas B. Fitzpatrick, M.D., Ph.D.
Harvard Medical School

Fee: \$220.00

Credit: 13½ AMA Category 1 Credit Hours

Contact: Kathy E. Johnson, Box 48, MCV Sta-
tion, Richmond, VA 23298 (804)
786-0494

United Hospital Fund of New York

in conjunction with

Albert Einstein College of Medicine /
Montefiore Hospital and Medical Center /
Diabetes Research and Training Center

and

American Diabetes Association,
New York Affiliate, Inc.

presents

NEW TECHNOLOGY IN DIABETES CONTROL

a 1-day conference for physicians
and other health professionals

featuring skills development workshops
on

Monday, December 7, 1981

Yeshiva University, New York City

For further information, contact Dena Seiden,
United Hospital Fund of New York,
(212) 754-1080, ext. 259.

- 6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section of AMNJ*)
- 6 **Special Problems in Hypertension**
13 **Risk Factors in Heart Disease**
20 **Advances in Nutrition**
27 **Is Atherosclerosis Reversible?**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 6 **Endocrine Conferences**
13 3:30-5 p.m.—Rotates between Newark
20 Beth Israel Medical Center, College
27 Hospital, Newark and VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
- 7 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(*Endocrinology Section of AMNJ*)
- 8 **Medical Grand Rounds**
11:30 a.m.—College Hospital, Newark
(*Endocrinology Section of AMNJ*)
- 8 **Workup of the Patient with F.U.O.**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 8 **Proper Use of Antibiotics**
22 **Colitis: Extra Colonic Manifestations**
12 noon—Freehold Area Hospital
(*AMNJ*)
- 8 **Topic to be announced**
15 **Infectious Arthritis**
22 **Medical Mortality Conference**
29 **Cushing Syndrome**
8:30-9:30 a.m.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)
- 13 **Inflammatory Bowel Disease**
9:30-11:30 a.m.—Dover General Hospital
(*Dover General Hospital and Medical Center and AMNJ*)
- 14 **Endocrine Aspects of Aging**
21 **Endocrine Aspects II**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)
- 15 **Renal Conferences in Nephrology**
4-5 p.m.—College Hospital, Newark
(*Nephrology Society of NJ and AMNJ*)
- 18 **Adrenal Dysfunction**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
- 19 **CPR**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 19 **Drug-Induced Liver Disease**
12 noon-1 p.m.—St. Mary's Hospital, Orange
(*AMNJ*)
- 20 **Workup of a Case of Anemia**
1-2:30 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 20 **Rutgers Dermatological Conference**
6-9 p.m.—Rutgers Community Health Plan, 57 U.S. Highway 1, New Brunswick
(*Rutgers Medical School and AMNJ*)
- 21 **Hypertension—Simpler Diagnosis, Newer Management Methods**
- 5-6:30 Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
- 26 **Functional Abnormalities of Chronic Lymphocytic Leukemia Lymphocytes**
7-9 p.m.—Coachman Inn, Jackson Dr., Cranford
(*NJ Blood Club and AMNJ*)
- 28 **Case Presentations**
8-10 p.m.—St. Barnabas Medical Center, Livingston
(*NJ Society for Gastrointestinal Endoscopy, Somerset Medical Center and AMNJ*)
- NEUROLOGY/PSYCHIATRY**
- Dec.**
- 1 **Inpatient Psychiatry**
9 **Family Life Cycle**
1-3 p.m.—Ancora Psychiatric Hospital, Hammonont
(*Ancora Psychiatric Hospital and AMNJ*)
- 1 **Psychiatric Case Conferences**
8 7:30-9:30 a.m.—Trenton Psychiatric Hospital
15 **Hospital**
22 (*Trenton Psychiatric Hospital and AMNJ*)
29 **Child Psychiatry Case Conferences**
9 8:30-10:30 a.m.—Trenton Psychiatric Hospital
16 **Hospital**
23 (*Trenton Psychiatric Hospital*)
30
- 3 **Hypnosis in Medicine and Allied Professions**
10 **Psychiatric Lecture Series**
17 1:30-5 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 4 **Psychiatric Lecture Series**
1:30-5 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 5 **Alcoholics Anonymous and Psychiatry**
9:15 a.m.-4:30 p.m.—Rider College, Lawrenceville
(*Carrier Foundation and AMNJ*)
- 7 **Guillain-Barré Syndrome**
21 **Autonomic Nervous System Dysfunction in Man**
11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)
- 7 **Followup Presentation of Pathological Diseases**
8-10 p.m.—4 Garden Place, Nutley
(*Essex Psychiatric Seminar and AMNJ*)
- 8 **Organic Basis for Mental Illness**
2 p.m.—Ancora Psychiatric Hospital, Hammonont
(*AMNJ*)
- 8 **Differential Diagnosis of Anemias**
11 a.m.-12 noon—Greystone Park Psychiatric Hospital
(*AMNJ*)
- 9 **Biochemistry of Depression and Its Application to Psychiatric Practice**
8:30-10:30 p.m.—Guido's Restaurant, Hackensack
(*North Jersey Psychiatric Society and AMNJ*)
- 9 **Update on Drug Addiction**
1:30 p.m.—Trenton Psychiatric Hospital
- Jan.**
- 4 **Behavior Disorder Secondary to Orthopedic Problems**
8-10 p.m.—11 Ridgewood Ave., Glen Ridge
(*Essex Psychiatric Seminar and AMNJ*)
- 5 **Psychiatric Case Conference**
12 7:30-9:30 a.m.—Trenton Psychiatric Hospital
19 **Hospital**
26 (*Trenton Psychiatric Hospital and AMNJ*)
- 6 **Child Psychiatry Case Conference**
13 8:30-10:30 a.m.—Trenton Psychiatric Hospital
20 **Hospital**
27 (*Trenton Psychiatric Hospital and AMNJ*)
- 6 **Dream Analysis**
13 **Psychological Approach to Chronic Pain**
20 **What are Hospices All About?**
27 **Behavior Therapy for Psychiatric Settings**
1-3 p.m.—Ancora Psychiatric Hospital
(*Ancora Psychiatric Hospital and AMNJ*)
- 7 **Hypnosis in Medicine and Allied Professions**
14 **Professions**
21 3:30-7:30 p.m.—Carrier Foundation, Belle Mead
(*Carrier Foundation and AMNJ*)
- 8 **Pediatric Subspecialties**
8:15-9:45 a.m.—Overlook Hospital, Summit
(*Overlook Hospital, Columbia University and AMNJ*)
- 13 **Somatoform Disorders in DSM III**
1:30-3:30 p.m.—Trenton Psychiatric Hospital
(*Trenton Psychiatric Hospital and AMNJ*)
- 13 **Peripheral Neuropathy**
2 p.m.—John E. Rannels Hospital, Berkeley Heights
(*AMNJ*)
- 19 **Polycythemia**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
- 20 **Male and Female Homosexuality**
1-2:30 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
- 28 **Neuroendocrine Aging**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)

JEFFERSON MEDICAL COLLEGE

of

THOMAS JEFFERSON UNIVERSITY



Symposium—Clinical Strategies in Cardiology and Hypertension

Dates—December 4 and 5, 1981

**Location—Bellevue Stratford Hotel
Philadelphia, Pa.**

Fee—Attending Physicians	\$30
House Officers	\$10
Medical Students	\$ 5
<i>(Fee includes Friday luncheon)</i>	

The symposium will include an in-depth review of recent advances in cardiac diagnosis and therapy including Calcium Channel Blockers, Coronary Artery Spasm, Clinical Pharmacology of Newer Beta Blockers, Surgical and Pacemaker Therapy of Cardiac Arrhythmias, Balloon Angioplasty and the Pre-excitation Syndromes.

Faculty will include:

Eugene Braunwald, M.D. (Harvard Medical School), David B. Case, M.D. (The New York Hospital), Doris Escher, M.D. (Albert Einstein College of Medicine), M. Irene Ferrer, M.D. (Columbia University College of Physicians and Surgeons), Ray W. Gifford, Jr., M.D. (The Cleveland Clinic), Richard Gorlin, M.D. (Mt. Sinai School of Medicine), Leonard N. Horowitz, M.D. (Hahnemann Medical College), Bernard Segal, M.D. (Hahnemann Medical College), Donald Vidt, M.D. (The Cleveland Clinic) and members of the Department of Medicine of Jefferson Medical College.

For further information write or call:

**Robert Mackowiak, M.D.
Office of Continuing Medical Education
Jefferson Medical College
1025 Walnut Street
Philadelphia, PA 19107
(215) 928-6992**

OBSTETRICS/GYNECOLOGY

Dec.

- 16 Ovarian Cancer**
1:30-2:30 p.m.—Rutgers Community Health Plan-57 U.S. Highway #1, New Brunswick
(*Rutgers Community Health Plan and AMNJ*)

17 Reproductive System

4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)

18 Eclampsia (DIC)

12 noon—Freehold Area Hospital
(*AMNJ*)

PATHOLOGY

Dec.

- 30 Clinical Pathology Conference**
9:30-11:30 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)

Jan.

- 9 Blood Cells and Immune System**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)

PEDIATRICS

Dec.

- 10 Pediatric Developmental Diagnosis**
3:30 p.m.-7:45 p.m.—Carrier Foundation
(*Carrier Foundation and AMNJ*)

- 11 Lecture Series—Pediatric Subspecialties**
8:15 a.m.-9:45 a.m.—Overlook Hospital, Summit
(*Overlook Hospital, Columbia University College of Physicians and Surgeons and AMNJ*)
- 21 Antenatal Detection of Genetic Disorders**
12 noon-1 p.m.—Mountainside Hospital, Montclair
(*Mountainside Hospital and AMNJ*)

RADIOLOGY

Dec.

- 16 Nuclear Medicine and the Kidney**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
- 23 Use of Computed Tomography in Stroke**
9:30-11:30 a.m.—Bergen Pines County Hospital, Paramus
(*Bergen Pines County Hospital and AMNJ*)

Jan.

- 7 Ultrasound Use and Interpretation in Infancy and Childhood**
9 a.m.—Freehold Area Hospital
(*AMNJ*)

GENERAL SURGERY

Dec.

- 2 Fall 1981 Clinical Abstract Meeting**
1 p.m.—The Manor, West Orange
(*The Oncology Society of NJ and AMNJ*)
- 5 Annual Meeting**
9 a.m.—Rutgers Medical School, Piscataway
(*NJ Chapter, American College of Surgeons*)

Jan.

- 6 Breast Cancer**
10:30 a.m.—St. Mary's Hospital, Passaic
(*AMNJ*)
- 26 Surgical Management of Pressure Sores**
8-10 p.m.—Englewood Club, Englewood
(*Englewood Surgical Society, Englewood Hospital and AMNJ*)

SURGICAL SPECIALTIES (includes ENT, Neurosurgery, Ophthalmology, Orthopedic, Plastics, and Vascular Surgery)

Dec.

- 2 Endocrine Surgery**
1-2:30 p.m.—Christ Hospital
(*AMNJ*)
- 4 Update on Plastic Surgery**
8:30-9:30 a.m.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)
- 9 Dinner Meeting**
6:30-10:30 p.m.—The Manor, West Orange
(*NJ Society of Colon and Rectal Surgeons*)

Jan.

- 26 Plastic Surgery-Reconstructive/Cosmetic**
8 p.m.—Warren Hospital, Phillipsburg
(*AMNJ*)

MISCELLANEOUS

Jan.

- 13 DRG and You**
1-2:30 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)

**216th Annual Meeting
May 14-17, 1982**

Resorts International, Atlantic City

Proposed Daily Schedule

Friday, May 14, 1982

- 3:30 p.m.—Board of Trustees' Meeting
5:00 p.m.—Delegate Registration

Saturday, May 15, 1982

- 7:30 a.m.—Delegate Registration
9:00 a.m.—House of Delegates
9:00 a.m.—Message Center, Coffee Lounge, Exhibits, Auxiliary Arts and Hobbies Open
10:30 a.m.—House of Delegates (election)
12:00 noon—Golden Merit Award Ceremony followed by Reception for Award Recipients
1:00 p.m.—Reference Committee Meetings: "A", "B", "C", "D", "E", "F", "G", "H", Constitution and Bylaws
6:00 p.m.—JEMPAC Wine and Cheese Reception

Sunday, May 16, 1982

- 7:00 a.m.—JEMPAC Breakfast
8:00 a.m.—Registration Opens

- 9:00 a.m.—Message Center, Coffee Lounge, Exhibits, Auxiliary Arts and Hobbies Open
9:00 a.m.—Scientific Sessions
1:00 p.m.—Scientific Sessions
4:00 p.m.—Annual Meeting—Board of Governors of MILE
6:30 p.m.—Inaugural Reception
8:00 p.m.—Inaugural Dinner

Monday, May 17, 1982

- 8:00 a.m.—Registration Opens
9:00 a.m.—Message Center, Coffee Lounge, Exhibits, Auxiliary Arts and Hobbies Open
9:00 a.m.—House of Delegates (to consider reference committee reports)
12:00 noon—Message Center, Coffee Lounge, Exhibits, Auxiliary Arts and Hobbies Close
12:00 p.m.—House of Delegates adjourns for lunch
1:30 p.m.—House of Delegates reconvenes
4:00 p.m.—House of Delegates adjourns
7:00 p.m.—Board of Trustees' Dinner-Meeting

OBITUARIES

Dr. Franklin J. Besson

Franklin J. Besson, M.D., former chief of staff at Irvington General Hospital, died on October 4 in Overlook Hospital, Summit. A native of New Jersey, Dr. Besson earned his medical degree at Georgetown University Medical School, class of 1937, and established a practice in obstetrics and gynecology in Irvington where he also lived until eight years ago when he retired to Whiting. He was a member of the department of obstetrics and gynecology at Irvington General Hospital for 36 years, and head of that department for 24 years. Dr. Besson served as chief of staff from 1951 to 1953 and again from 1965 to 1967. He was a Fellow of the American College of Obstetricians and Gynecologists. During World War II Dr. Besson served in the United States Navy. He is survived by a son who bears his name and is also a physician. Dr. Besson was 72 years old at the time of his death.

Dr. Robert Brill

A member of our Passaic County component, Robert Brill, M.D., of Fort Lee, who was director of laboratories at St. Mary's Hospital in Passaic, died at his home on August 12. A native of New York City, born in 1913, Dr. Brill was graduated from Long Island University College of Medicine in 1939 and pursued graduate training in pathology, becoming board certified by the American Board of Pathology and the American Board of Nuclear Medicine. He had been associated with St. Mary's medical staff since 1949 and formed the blood bank there; he also established a school of medical technology and expanded the hospital's laboratory. He was the co-founder of the first tissue audit committee in the country. In addition to his work at St. Mary's Hospital, Dr. Brill served as director of laboratories at South Bergen Hospital in Hasbrouck Heights, was director of cytology for the board of health of Paterson and was clinical professor of pathology at New Jersey Medical School, CMDNJ, Newark. He was a Fellow of the American

Society of Clinical Pathologists and of the American College of Pathologists and served as an inspector for the Commission on Laboratory Inspection and Accreditation, the American Association of Blood Banks and the National Accrediting Agency for Clinical Laboratory Sciences. Dr. Brill was a past president of the New Jersey Society of Pathologists. He had been active in Medical Society affairs and held a three-year term on the state society's Committee on Annual Meeting. During World War II Dr. Brill served with the medical department of the AUS.

Dr. Charles P. Campbell

A former secretary of the Bergen County Medical Society, Charles P. Campbell, M.D., died on September 26. A native of New Jersey, born in 1912, Dr. Campbell was graduated from Columbia College of Physicians and Surgeons in 1938. He practiced general medicine in the Hackensack area for over 35 years and was a member of Hackensack Hospital's emergency room staff. Dr. Campbell was active in Medical Society affairs, having served on MSNJ's Committee on Credentials for three years and on the Committee on Emergency Medical Care for four years. During World War II he was a member of the United States Air Force with the rank of lieutenant colonel.

Dr. Thomas E. Cantalupo

Word just has reached us of the death on August 21 of Thomas Emidio Cantalupo, M.D., a member of our Essex County component. A native of Newark, New Jersey, Dr. Cantalupo earned his medical degree at the Royal University of Rome (Italy) in 1936 and, upon his return to the United States, established a practice in general medicine in his native city. He was on the staff at Columbus and St. James Hospitals in Newark. Dr. Cantalupo was 74 years old at the time of his death.

Dr. Louis Danzls

One of Essex County's senior members, Louis Danzls, M.D., formerly

from South Orange, died in Paul Kimball Hospital, Lakewood, on September 14. A native of New Jersey, born in 1906, Dr. Danzls was graduated from the Royal College of Physicians in Edinburgh (Scotland) in 1933 and practiced general medicine and surgery in Newark for many years. He closed his private practice and accepted a position as physician for New Jersey Manufacturers Insurance Company in 1965. He had retired from the latter position in 1972 and moved to Lakewood. During World War II, Dr. Danzls served with the medical department of the AUS.

Dr. Janet L. Eckhardt

Janet L. Eckhardt, M.D., a member of our Morris County component, died on September 1 in Morristown Memorial Hospital. A graduate of the University of Rochester Medical School, class of 1943, Dr. Eckhardt pursued a career in pediatrics and had been a member of the staff at Morristown Memorial Hospital. In 1969 Dr. Eckhardt gave up private practice and accepted an appointment as director of clinical research for Warner-Lambert Company, retiring in 1975 because of illness.

Dr. John G. Falcone

John G. Falcone, M.D., a member of our Middlesex County component, died on September 6. Born in 1926, Dr. Falcone earned his medical degree from the University of Rome School of Medicine and Surgery in 1957, pursued a residency in obstetrics and gynecology at St. Clare's Hospital in New York City, and came to New Brunswick to establish a practice. He was affiliated with St. Peter's Hospital there.

Dr. C. Malcolm B. Gilman

On August 26, C. Malcolm B. Gilman, M.D., a senior member of our Monmouth County component, died in Monmouth Medical Center, Long Branch. A native of New Jersey, Dr. Gilman earned his medical degree from Cornell University Medical School in 1927 and pursued a career in surgery and subsequently in aviation medicine. He

was a Fellow of the American Society of Abdominal Surgeons and had been on the staff at St. James Medical Center and Presbyterian Hospital in Newark and the E.C. Hazard Hospital in Long Branch. Dr. Gilman was active in community affairs and had been police and fire surgeon for Middletown Township and health officer and police and fire surgeon for the communities of Bay Head and Mantoloking. He was an expert on colonial New Jersey history, especially the Revolutionary War, and had written four volumes on that period. Dr. Gilman was a member of the Society of the Sons of the American Revolution. In 1977 he was a recipient of MSNJ's Golden Merit Award in recognition of his 50 years as a physician. He was 83 years old at the time of his death.

Dr. Paul J. Isen

Word just has been received of the sudden death following a myocardial infarction of Paul J. Isen, M.D., on July 21 at Monmouth Medical Center, Long Branch. A graduate of the Medical College of Dalhousie University (Nova Scotia) class of 1939, Dr. Isen came to New Jersey to practice general medicine and was affiliated with both Monmouth Medical Center in Long Branch and Jersey Shore Medical Center at Neptune.

Dr. Dorothy P. Moore

A member of our Bergen County component, Dorothy P. Moore, M.D., of Ridgewood, died on August 21 at her home. A native of Pennsylvania, Dr. Moore earned her medical degree at Hahnemann Medical College in Philadelphia, class of 1949, and came to Ridgewood twenty-five years ago to establish a practice in internal medicine. She had been affiliated with the Valley Hospital there.

Dr. Norman L. Murray

Norman L. Murray, M.D., an internist who specialized in diabetes, died on August 18 at Overlook Hospital in Summit. Born in Bangalore, India, Dr. Murray earned his medical degree from the University of Toronto School of Medicine in 1931 and pursued graduate training in internal medicine becoming board certified in that field. He was a Fellow of the American College of Physicians and a member of the American Diabetes Association. Dr. Murray had been chief of the department of internal medicine at Overlook Hospital, retiring

in 1979. He had been affiliated also with St. Barnabas Medical Center in Livingston. During World War II Dr. Murray served in the medical department of the AUS. He was 78 years old at the time of his death.

Dr. James J. O'Grady

Word just has been received of the sudden death on June 26 at St. Mary's Hospital, Orange, of James J. O'Grady, M.D., following a cerebral hemorrhage. A native of New Jersey, born in 1927, Dr. O'Grady was graduated from Creighton University Medical School in 1973 and following a residency at St. Michael's Medical Center in Newark, established a practice in internal medicine and gastroenterology in Maplewood. He held staff appointments at St. Michael's, and at St. Mary's Hospital in Orange and St. Barnabas Medical Center in Livingston.

Dr. Ralph S. Phillips

A member of our Cumberland County component, Ralph S. Phillips, M.D., died in Bridgeton Hospital on September 14 after a lengthy illness. A native of Bridgeton, born in 1913, Dr. Phillips earned his medical degree at Hahnemann Medical College in 1945 and practiced general medicine in his home town for thirty years until failing health forced his retirement in 1978. He served as treasurer of his county society for several years and was president of the Bridgeton Hospital's medical staff in 1952. During World War II Dr. Phillips served in the medical branch of the AUS.

Dr. Roy Plotkin

At the untimely age of 57, Roy Plotkin, M.D., an anesthesiologist and a member of our Morris County component, died on September 22. A native of England, Dr. Plotkin emigrated to the United States in 1948, and returned to the British Isles where he earned his medical degree from the University of Scotland, class of 1959. He served his internship at Kings County Hospital Center in Brooklyn and practiced general medicine until 1968 when he took graduate training in anesthesiology and restricted his practice to that specialty. Because of chronic illness, Dr. Plotkin's practice reflected periods of inactivity, however, he did serve for a time as chief of anesthesiology at South Amboy Memorial Hospital. He was board certified in his specialty and a Fellow of the American College of Anesthesiologists.

Dr. Frank L. Rosen

We just have learned of the death on August 6 of Frank L. Rosen, M.D., a well-known allergist of Maplewood. A member of our Essex County component, Dr. Rosen was born in Brooklyn in 1909 and was graduated from Long Island College of Medicine, class of 1933, after which he pursued a residency in his specialty. He was affiliated with Newark Beth Israel Medical Center and was chief of the allergy clinic at the Newark City Dispensary. Dr. Rosen was a Fellow of the American and International Colleges of Allergy and was active in medical society affairs. He served on MSNJ's Committee on Air Pollution Control, later renamed the Committee on Environmental Health, from its inception. Dr. Rosen also served as chairman of his county's Air Pollution Committee and was editor of the Essex County *Bulletin* for 25 years. In 1977 he received a certificate of appreciation from the United States Environmental Protection Agency. During World War II Dr. Rosen served in the medical department of the AUS emerging with the rank of major.

Dr. Generoso Rossi

On September 13, Generoso Rossi, M.D., formerly of Bound Brook, died at his home in Tampa, Florida. Dr. Rossi earned his medical degree from the University of Siena (Italy) in 1937 and returned to his native New Jersey to establish a practice in general medicine and pediatrics. He had been a member of the pediatric staff at Somerset Hospital in Somerville. He later pursued training in tropical medicine and more recently had been affiliated with the Veterans Administration Hospital in Tampa. During World War II Dr. Rossi served with the medical department of the AUS.

Dr. Sidney A. Rothman

A member of our Mercer County component, Sidney A. Rothman, M.D., died suddenly on September 13 at St. Francis Medical Center, Trenton. A native of New York City, Dr. Rothman earned his medical degree from the University of Lausanne (Switzerland) in 1941 and returned to New Jersey to establish a general practice. He subsequently devoted his attention primarily to cardiology and was a member of that department at St. Francis Medical Center. During World War II Dr. Rothman served with the medical department of the AUS.

Dr. Israel N. Schenker

We just have learned of the death on August 12 of Israel N. Schenker, M.D., a member of our Hudson County component. A native of New Jersey, Dr. Schenker earned his medical degree at the Cincinnati Eclectic College in 1939 and returned to Jersey City to establish a general practice, later specializing in occupational medicine and general surgery. He had been affiliated with the Medical Center, Greenville and St. Francis Hospitals in Jersey City, and North Hudson Hospital in Weehawken. Dr. Schenker was 73 years old at the time of his death.

Dr. Jacob M. Schildkraut

We just have learned of the death on August 5 in St. Francis Medical Center, Trenton, of Jacob M. Schildkraut, M.D., a retired dermatologist and renowned Jewish and civic leader. Born in Philadelphia, Dr. Schildkraut earned his medical degree at the University of Pennsylvania's School of Medicine in 1912, became board certified in his specialty, and conducted a practice in the Trenton area for over 50 years prior to retirement in 1975. He was active in medical affairs, having served as president of the Mercer County Medical So-

ciet, and twice as president of the Philadelphia Dermatological Society. Dr. Schildkraut also was president of the staff at St. Francis Hospital from 1960 to 1962. He was active in international dermatological conferences and was an honorary member of the Australian Dermatological Society. Dr. Schildkraut was the fifth physician to receive the Professional Award of the New Jersey Division of the American Cancer Society. He received recognition for his many endeavors in civic affairs and in his religion. In 1955 Dr. Schildkraut received Israel's Distinguished Leadership Award for "highest service to Israel's economic development." In 1981 he was honored as the founding father of B'nai B'rith Lodge 1268 in Trenton. Dr. Schildkraut served as president of Har Sinai Jewish Congregation for 25 years, and he was a past president of the Trenton Jewish Community Center. In 1962 he received MSNJ's Golden Merit Award indicating fifty years of medical practice. Dr. Schildkraut was 90 years old at the time of his death.

Dr. Samuel J. Soschin

Word just has been received of the death at Newark Beth Israel Medical Center on July 6 of Samuel J. Soschin, M.D. A graduate of Bellevue Hospital Medical College, New York in 1922, Dr.

Soschin practiced general surgery in Essex County for many years and had been affiliated with Beth Israel Medical Center, St. James and Presbyterian Hospitals in Newark and St. Barnabas Medical Center in Livingston. He was a Fellow of the American College of Surgeons. In 1972 Dr. Soschin was a recipient of MSNJ's Golden Merit Award indicating 50 years of medical practice. During World War II, he served with the medical department of the AUS.

Dr. H. Garrett Vander Veer

At the grand age of 83, H. Garrett Vander Veer, M.D., a member of our Essex County component and formerly from Bloomfield, died on August 16 at Crouse-Irving Memorial Hospital in Syracuse, New York. Dr. Vander Veer was born in Onondaga County in New York and earned his medical degree from Syracuse University Medical College, class of 1928. The next year he came to New Jersey to accept a staff appointment at St. Michael's Medical Center in Newark. He also had been affiliated with Mountainside Hospital in Montclair. Dr. Vander Veer retired in 1951 for reasons of health and moved to Skaneateles, New York. In 1975 he was a recipient of MSNJ's Golden Merit Award in recognition of his 50 years as a physician.

BOOK REVIEW

Practical Pediatrics: Selected Abstracts

Richard H. Rapkin, M.D. Editor. Littleton, MA, John Wright-PSG Inc., 1981. Pp. 227 (\$22.50)

A strong candidate for recognition as the Sidney Gellis of the 1980s will be Dr. Richard Rapkin, collector of the monthly Abstract and Comment Service of the New Jersey Medical School, Department of Pediatrics, wit, raconteur and

all-around entertaining commentator on pediatric practice.

This book is a collection of abstracts, I believe most if not all from his monthly "Newsletter." Usually important, always pertinent and of value as much for his comments and wide-ranging associations as for the reminder of the original article itself.

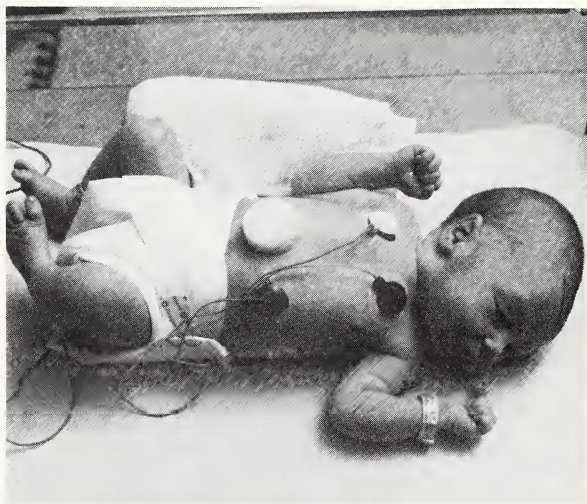
The main problem of this volume is that it is a collection of miscellany which

is not well indexed. There are chapters and subjects but it is not a reference to which one can go to find out specifically about Topic A or Topic B. It is rather a book for leisure browsing and stimulation of thinking.

We all hope Dr. Rapkin will keep up his good work and that the next volume will possess, in addition to his comments, a careful index.

Avrum L. Katcher, M.D.

We want to take heart defects out of the nursery.



It almost breaks your heart to see it. She's two days old and there's a question about a hole in her heart. She's fortunate. Something can be done about it. Each year, 25,000 infants are born with heart defects which can disable them for life.

The American Heart Association is fighting to reduce this form of early death and disability with research, professional and public education, and community service programs.

But more needs to be done.

You can help us save young lives by sending your dollars today to your local Heart Association, listed in your telephone directory.

**Put your money where
your Heart is.**



**American
Heart
Association**

WE'RE FIGHTING FOR YOUR LIFE

COLLECTION SERVICES

FEES:

- (1) Collection from first letter only - -
10 % of amount collected (min. \$30 fee)
- (2) Collection from further contact - -
28% of amount collected (min. \$30 fee)

References	David B. Watner	(201)
Available	Attorney at Law	736-8862
Upon	P.O. Box 94	
Request	Short Hills, N.J. 07078	

NEEMA EMERGENCY MEDICAL —a professional association—

Emergency Medicine Positions—available with emergency physician group in FL, PA, NY, NJ, VA, WV, KY, MD and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical
Suite 400 or phone
399 Market Street in Pa., (215) 925-3511
Philadelphia, Pa. 19106 outside Pa., 800-523-0776

RESIDENCY IN PHYSICAL MEDICINE AND REHABILITATION

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$17,500 to \$20,100 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

Are your dental bills taking
a bite out of your savings?

ANNOUNCING:

A Medical Society of New Jersey Sponsored GROUP DENTAL INSURANCE PLAN

FEATURING:

- "Usual, Customary and Reasonable" (UCR) benefit payments that increase with inflation
- Only a \$25 deductible
- Orthodontia benefits
- PLUS all the advantages of a group insurance program

Look for your Group Dental Insurance Plan booklet and application in the mail
Administered by

DONALD F. SMITH & ASSOCIATES

A multi-line
insurance consulting
and brokerage firm

One Airport Place, Route 206 North, P.O. Box 2197, Princeton, New Jersey 08540 (609) 924-8700 (201) 622-6046
Underwritten by New Jersey Dental Service Plan, Inc.

CLASSIFIED ADVERTISEMENTS

ANESTHESIOLOGIST—Board eligible. Seeks Group, solo, partnership, hospital based. Also willing to work in ER. Available on one month notice. Hossain Esmail, M.D., P.O. Box 1017, Franklin, VA 23851.

DIAGNOSTIC RADIOLOGIST—Trained in all phases. Available for Part-time, locums and consultation service in Northern New Jersey. Contact Box No. 275, c/o JOURNAL MSNJ.

FAMILY PRACTITIONER—Board eligible. Desires group. Penn State Hershey graduate 1979. Available August 1982. Write Box No. 272, c/o JOURNAL MSNJ.

GENERAL SURGEON—University trained. Doing a fellowship in vascular surgery. Seeks position for August 1982. Contact Ruben J. Delgado, M.D., Spring Ridge M-26, Whitehall, PA 18052.

INTERNIST—Cardiologist, young, interested in joining practice in New Jersey. Strong university training. Board certified in internal medicine. Extensive experience clinical, invasive and non-invasive cardiology. A. Losardo, M.D. (212) 645-5190.

INTERNIST—Training and experience in hematology/oncology. ABIM, U of P Med. Wishes to associate or buy. Write Box No. 241, c/o JOURNAL MSNJ.

INTERNIST—To buy established practice, or seeks solo, group or partnership. Board certified, 29, practicing two years. Desires to relocate in New Jersey. Available July 1982. Write Box No. 265, c/o JOURNAL MSNJ.

INTERNIST-RHEUMATOLOGIST—ABIM, both with excellent clinical teaching/practice experience. Desires association with subspecialty group/partnership in New Jersey. Write Box No. 270, c/o JOURNAL MSNJ.

M.D.—Wishes to cover general practice on afternoon or evening hours. Sublease arrangement possible. Call evenings. (201) 567-6282.

OTOLARYNGOLOGY—Board certified with broad experience. Seeking group, partnership; will consider solo. Available August 1982. Write Box 269, c/o JOURNAL MSNJ.

PEDIATRICIAN—Wishes to buy active practice in NJ or become associate with a pediatrician. Would also consider position in medical group. Board eligible, hospital affiliated. Write Box No. 267, c/o JOURNAL MSNJ.

PEDIATRICIAN—To associate with another pediatrician. Excellent opportunity. Essex County. Write Box No. 266, c/o JOURNAL MSNJ.

INFORMATION FOR MEMBERS—RATES:—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JOURNAL MSNJ" as six words. **COPY DEADLINE:** Fifth of preceding month.

NEEDED—ASSOCIATE—Pediatrician, board certified seeks associate for moderate size Middlesex County practice with unhurried atmosphere and individual patient care. Excellent deal with early equal partnership. Write Box No. 274, c/o JOURNAL MSNJ.

NEEDED—M.D.—Board eligible or certified internist-cardiologist to associate with group in rapidly growing area in Ocean County, N.J. Salary with eventual partnership. Please send curriculum vitae to: Box No. 261, c/o JOURNAL MSNJ.

OFFICE EQUIPMENT WANTED—Wish to purchase examining tables, and other office equipment and supplies for use in a general medical practice. Allan Lazar, M.D., P.O. Box J, Teaneck, NJ 07666 (201) 568-3742.

FAMILY PRACTICE FOR SALE—Busy solo Family Practice in Budd Lake, N.J., just off Route 80 in Lakeland area of Morris County. Only Family Practice in large still growing town. Three examination rooms, laboratory, consulting room, waiting room, reception area all purpose room. Fully equipped. Very low rent. 9 year lease. Call (201) 376-3526 or 691-0800.

GYNCOLOGY PRACTICE FOR SALE—Established 20 years in New Brunswick. 1460 square feet available. Total facility allows for 2 practices. Ideal situation for some looking to start Gyn practice. Office fully furnished and well equipped. Minutes away from 2 major hospitals. Available immediately. Terms negotiable. (201) 246-3059.

PRACTICE FOR SALE—Englewood Hospital Area, Bergen County. Internal Medicine and Family Practice. Practice is large enough to support 2 physicians. Principals only. Building and equipment negotiable. Write Box No. 262, c/o JOURNAL MSNJ.

MEDICAL PRACTICE/BUILDING FOR SALE—Well established internal medicine practice/office building in Princeton, NJ. Write Box No. 276, c/o JOURNAL MSNJ.

MEDICAL PRACTICE/OFFICE FOR SALE—Owner retiring. Established practice of internal medicine and luxurious 1300 square foot office for sale in exclusive Hackensack, NJ. Co-op apartment house. Patient parking available. Office 3 blocks from Hackensack Medical Center. Box No. 277, c/o JOURNAL MSNJ.

FOR SALE—Internal Medicine Practice in Jersey City. Good for specialist and General Practice. Contact: (201) 434-7800 Dr. R. Nayyag.

FOR SALE—Home/Office/Furnishings, due to death of GP. Small town location, N.W. New Jersey. Two hospitals nearby. Excellent opportunity for family practitioner or internist. Call (201) 689-1705.

FOR SALE/LEASE—Doctor's Office fully equipped and furnished. Equipment and furnishings may be purchased. Lease available. Small modern medical building, parking. Call (201) 273-8040.

OFFICE SPACE—2 Locations—To rent or share, furnished, very reasonable. Fair Lawn, Bergen County also in Ridgewood, Bergen County. Write Box No. 273, c/o JOURNAL MSNJ.

OFFICE SPACE—Kenilworth. For rent, medical office. Call (201) 272-5750.

OFFICE SPACE—Middlesex County, Edison. Attractive new building centrally located, near hospitals, major highways. Last section, 775 square feet available. Subspecialties needed. M.R. Bronstein, M.D. (201) 738-8000.

OFFICE SPACE—Montclair, 1200 feet, large waiting room, business office, three examining rooms. Commercial district, two blocks from Mountaineer Hospital. Adequate parking. Call (201) 744-4941.

OFFICE SPACE—Moorestown. Space to rent, 701 E. Main Street. Custom medical offices in the new wing. Building to be completed winter 1981. (609) 235-2651.

OFFICE SPACE—Morris County. For rent, office space available on part time basis. Excellent central location. Superb parking. Contact: (201) 376-4539 evenings or (201) 473-0063 days 10-4.

OFFICE SPACE—Northern NJ. Available one private exam room and share fully furnished waiting room, business office, auxiliary exam room. Excellent exposure, close to hospital, near major hwy's., 30 minutes to NYC. Call evenings (201) 337-1627.

OFFICES AVAILABLE—Paterson. In air conditioned, very busy medical building with elevator and security. On-site parking. Across from St. Joseph's Hospital. Pharmacy in lobby. Need the following specialties: ophthalmology, orthopedics, otorhinolaryngology, oncology, neurology and dermatology. Call (201) 881-7800.

SUPER CONDO—Cancun, Mexico. Beachfront. Free snorkels, sunfish, tennis. Sleeps 5-6. Daily maid service. Available 11/21-12/5. \$750/week. Call Dr. King (201) 864-6457.

VAIL CONDO—Two bedrooms, kitchen, living room fireplace, beautiful view. \$570/week. Available Christmas and high season. Ralph Bloch, M.D., 1265 Race St., #501, Denver, CO 80206. (303) 425-0961 or 399-9076.

CME—See 847-851
Financial—See 856
Personnel—See 856, 857
Real Estate—See 857

DOCTOR . . . WE'VE GOT IT ALL TOGETHER IN A SUPER-SIZED RANCH

It's a beautiful home! It's office facilities! It's in prestigious Marlboro where there are 20,000 people in communities designed for either growing families or seniors.

The building, including the 8-foot high lower level, will be finished to your specifications to include expansive living facilities and a two-car garage plus ample space for a growing practice. There's an extra building lot for PARKING or INVESTMENT!

PRICE: Below Market Value. CALL (201) 329-6767

JACKSON, NEW JERSEY

Office space to rent or share in center with two groups of obstetricians, one general surgeon, one nephrologist. Ideal for someone starting in practice.

Call 201-477-2727 or 201-892-9499

**MEDICAL SUITE AVAILABLE
CRANFORD MEDICAL BUILDING**

Four room suite and waiting room at 19 Holly St. Well known location. All services supplied, reasonable rental and great opportunity for individual private practice.

**Call Warren K. Hanscom
(201) 276-4119**

**Why are New Jersey
Doctors
Investing
in a
New
Condo
Called
Ventnor on the Bay?**



Because they have discovered a tax shelter that combines ownership with regular rental income, along with an excellent potential for short term appreciation. Located just 1½ miles from booming Atlantic City, Ventnor luxury condominiums start at \$79,100 and range from studio to two-bedroom apartments. Picture windows, private balconies, individual heat and air, designer lobbies, an Olympic size pool, and more. At Ventnor, full time manager will rent your units and collect your rent.

When you buy, you will receive an investor's discount, and you will be eligible to deduct interest, depreciation, and some maintenance charges from your taxable income. We feel that Ventnor on the Bay is your best investment today.

But hurry. Our sales success has been unprecedented.



**Call or write Ventnor on the Bay
6101 Monmouth Ave.
Ventnor, N.J. 08406 (609) 823-7866**

**FOR SALE
MEDICAL/PROFESSIONAL
OFFICE**

- One block from PAUL KIMBALL HOSPITAL
- On major highway Route 9, Lakewood, N.J.
- Ample parking space

**CALL (201) 542-3382
Monday-Friday 9 AM-5 PM
Evenings (201) 464-2063**

Office Space Available

**MEDICAL/
PROFESSIONAL
OFFICES**

Prime Location:

NEW BRUNSWICK, N.J.

For information call 201-828-2715

December 1981

Journal of
the Medical
Society of

New Jersey

Foreign Bodies of the Rectum
B. I. Loigman, M.D., et al.

Current Drug Scene
Richard J. Russo, M.S.

Juvenile Rheumatoid Arthritis
Sheldon S. Solomon, M.D.

CMDNJ and Postgraduate
Physician Training
Carter Marshall, M.D.

Complete Table of
Contents on page 862

LIBRARY
U.C. SAN FRANCISCO
JAN 5 1982

The Library
Acquisitions Division
Univ. of Calif., San Francisco
Calif. 94143 S

**Send this coupon
for no-obligation
information
of the savings
under
the Medical
Society of
New Jersey
Endorsed
Insurance
Plans**

***Check this list
against your
coverages***

- ☐ \$4600 Monthly Guaranteed
Convertible Accident and
Health
- ☐ \$7,500 Monthly Practice
Overhead Expense
- ☐ \$1,250,000 Term Life Insurance
- ☐ \$200 Deductible Million-Dollar
Major Expense Plan for
Blue Cross Holders
- ☐ \$100-a-day Hospital Income
Policy
- ☐ \$200,000 High Limit Accident
Plan
- ☐ Keogh and Corporate Plan

**E. & W. Blanksteen
Agency, Inc.**

E. & W. Blanksteen
75 Montgomery St.,
Jersey City, N.J. 07302
(201) 333-4340
or (800) 742-2849

Name: _____

Address: _____

Tel. No. _____

Best Time To Call _____

How would you like Uncle Sam to pay for 100% of your life insurance...



and pay you a bonus for owning it?

Seem far fetched? It isn't. It not only can work, but it *does* work—as we've proven to many of our clients. And the entire procedure is fully supported by revenue rulings and sections of the internal revenue code.

In essence, this innovative concept developed by Richard G. Halpern Associates, works by allowing you to make a profit in the form of multiple deductions on both your income and estate taxes.

The concept does not fit everyone. It's designed for professional practices functioning within specific parameters. But it works in a surprising number of cases—and could well work in yours.



The point is, it will cost you nothing except a few minutes of your time to find out. We'd welcome the opportunity to discuss the plan with you at your convenience. Just call Rich Halpern at (201) 379-6723.

There's no obligation, of course, and all inquiries will be kept strictly confidential.

**RICHARD G. HALPERN
ASSOCIATES, INC.**

44 Fernhill Road, Springfield, New Jersey 07081

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

Officers and Trustees

PRESIDENT	Armando F. Goracci, M.D. (Gloucester)	Woodbury
PRESIDENT-ELECT	Howard D. Slobodien, M.D. (Middlesex)	Perth Amboy
FIRST VICE-PRESIDENT	Alexander D. Kovacs, M.D. (Union)	Scotch Plains
SECOND VICE-PRESIDENT	Frank Y. Watson, M.D. (Essex)	Montclair
IMMEDIATE PAST-PRESIDENT	Augustus L. Baker, Jr., M.D. (Morris)	Dover
SECRETARY	Arthur Bernstein, M.D. (Essex)	East Orange
TREASURER	Rudolph C. Gering, M.D. (Mercer)	Pennington

Trustees

CHAIRMAN	
William Greifinger, M.D. (1984) (Essex)	Belleville
Meyer L. Abrams, M.D. (1982) (Burlington)	Cherry Hill
Frank Campo, M.D. (1984) (Mercer)	Trenton
Douglas M. Costabile, M.D. (1984) (Union)	Murray Hill
John J. Crosby, Jr., M.D. (1984) (Hudson)	Jersey City
Anthony P. DeSpirito, M.D. (1982) (Monmouth)	Neptune City
Ralph J. Fioretti, M.D. (1983) (Bergen)	Rochelle Park
Palma E. Formica, M.D. (1984) (Middlesex)	Old Bridge
Harry W. Fullerton, Jr., M.D. (1982) (Salem)	Carney's Point
Sherman Garrison, M.D. (1983) (Cumberland)	Bridgeton
John P. Kengeter, M.D. (1984) (Ocean)	Toms River
Myles C. Morrison, Jr., M.D. (1982) (Morris)	Morristown
Michael R. Ramundo, M.D. (1984) (Passaic)	Clifton
Bernard Robins, M.D., (1983) (Essex)	Springfield

Councilors

FIRST DISTRICT	(Essex, Morris, Union and Warren Counties)
Edward M. Coe, M.D. (1984)	Cranford
SECOND DISTRICT	(Bergen, Hudson, Passaic and Sussex Counties)
Robert A. Weinstein, M.D. (1983)	Newton
THIRD DISTRICT	(Hunterdon, Mercer, Middlesex and Somerset Counties)
Albert F. Moriconi, M.D. (1982)	Trenton
FOURTH DISTRICT	(Burlington, Camden, Monmouth and Ocean Counties)
Frederick W. Durham, M.D. (1984)	Haddonfield
FIFTH DISTRICT	(Atlantic, Cape May, Cumberland, Gloucester and Salem Counties)
Ronald M. Fisher, M.D. (1983)	Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982)	Hackensack
William J. D'Elia, M.D. (1981)	Spring Lake
Frederick W. Durham, M.D. (1982)	Haddonfield
Karl T. Franzoni, M.D. (1982)	Trenton
John S. Madara, M.D. (1982)	Salem
Henry J. Mineur, M.D. (1982)	Cranford
Myles C. Morrison (1981)	Morristown



December 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Julio C. del Castillo, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.
Harold Arlen, M.D.
Alfonse Cinotti, M.D.
Stuart D. Cook, M.D.
Robert Dodelson, M.D.
Wm. A. Dwyer, Jr., M.D.
Norman H. Ertel, M.D.
A. Olusegun Fayemi, M.D.
Arthur Goldfarb, M.D.
Robert A. Goldstone, M.D.
Murray Kahn, M.D.
Monroe S. Karetzky, M.D.
Avrum L. Katcher, M.D.
Sidney Ketyer, M.D.
Bernard J. Koven, M.D.
Joel D. Levinson, M.D.
Henry R. Liss, M.D.
Robert M. MacMillan, M.D.
Geobel A. Marin, M.D.
Christopher M. Papa, M.D.
Victor Parsonnet, M.D.
Irwin Pollack, M.D.
Bernard A. Rineberg, M.D.
Edwin L. Rothfeld, M.D.
Benjamin F. Rush, Jr., M.D.
Morris H. Saffron, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Sheldon D. Solomon, M.D.
Lloyd N. Spindell, M.D.
A. Arthur Sugerman, M.D.
Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 931. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

WE SPEAK YOUR LANGUAGE

Professional Corporations
Retirement Plans
Tax Strategy
Tax Shelters
Estate Planning
Family Trusts
Office Management
Travel and Entertainment
Lease and/or Purchase

AND OURS

In these complex, rapidly changing times your C.P.A. should be able to speak both your language and today's up-to-the-minute, down-to-earth, bottom line accounting and taxes. We can.



Richard Maglin & Associates

We are experienced professionals able to translate your special needs into innovative successful strategies.

We can deal with the impact the changing tax laws have on your present and future taxes. We can plan, recommend and represent. We will, of course, provide timely preparation of your personal and corporate tax returns.

Phone us. Let us talk contemporary taxes and accounting.

Certified Public Accountant

Richard Maglin & Associates • 111 Northfield Avenue, West Orange, New Jersey 07052
(201) 736-9140

Journal of
the Medical
Society of

New Jersey

America's
First
Medical
Society

Volume 78
Number 13

Pages 859-942

866 PROFESSIONAL LIABILITY COMMENTARY

EDITORIALS

- 871 Competition in Medicine—The New Strategy
- 872 The Future of Medicine in the Eighties
- 874 "Hopefully" Will Disappear—I Hope!

877 JEMPAC REPORTORIAL

879 LIFELINE PROGRAM

ARTICLES

- 883 Nonsurgical Evaluation and Management of Malignant Biliary Tract Obstruction
B. I. Loigman, M.D., R. F. Mattern, M.D., R. F. Healey, M.D., T. H. Hayes, R.T., Montclair
- 887 Foreign Bodies of the Rectum
H. I. Garber, M.D., Baltimore; R. J. Rubin, M.D., T. E. Eisenstat, M.D., Plainfield
- 889 The Current Drug Scene
Richard J. Russo, M.S., Trenton

STATE OF THE ART

- 893 Juvenile Rheumatoid Arthritis
Sheldon D. Solomon, M.D., Cherry Hill

CASE REPORTS

- 897 An Unusual Cardiovascular Foreign Body: Discussion of Etiology and Nonoperative Retrieval
J. V. Cholankeril, M.D., S. Ketyer, M.D., O. Verzosa, M.D., F. Gural, R.T., Elizabeth
- 901 Primary Mediastinal Lipoma
R. F. Sarama, M.D., W.A. DiGiacomo, M.D., B.H. Safirstein, M.D., Newark

SPECIAL ARTICLE

- 903 CMDNJ and Postgraduate Physician Training in New Jersey
Carter Marshall, M.D., Newark

CLINICAL NOTE

- 907 Creation of a Loop Colostomy or Ileostomy with Immediate Application of Appliance
Mark J. Pello, M.D., William L. Beauregard, M.D., Camden

909 PEDIATRIC BRIEFS

COMMENTARY

- 911 "Pro-Competition": Panacea for Rising Health Care Costs Or Just the Opposite?
Anne R. Somers, Piscataway

DOCTORS' NOTEBOOK

- 915 Trustees' Minutes
- 918 CMDNJ Notes
- 918 MSNJ Auxiliary
- 920 Physicians Seeking Location in New Jersey

919 ANNUAL MEETING 1982—DAILY SCHEDULE

923 LETTER TO THE JOURNAL

925 CME CALENDAR

928 OBITUARIES

929 BOOK REVIEW

931 INDEX

Cover

The cover photograph, entitled, "Frozen Pond," taken in the Winter of 1978 at Hopkins Pond, Haddonfield, was offered to *The Journal* by John L. Krause, Jr., M.D., a member of our Camden County component, who has supplied cover material on many previous occasions.

216th Annual Meeting
May 14-17, 1982
Resorts International, Atlantic City



You're Invited to Tour Our Facilities

The majority of physicians have never toured a modern rehabilitation hospital, and because of this we're extending an open invitation.

New Jersey Rehabilitation Hospital, located by Exit 145 of the Garden State Parkway, is a specialty hospital which treats catastrophic injuries to spinal cord and brain, stroke, quadriplegic, paraplegia, loss of limb, musculo-skeletal injuries, neck and low back injuries, and other mental and physical impairments, often resulting from automobile or work accidents.

To arrange for an escorted tour of our facilities, call Bucky Harris, at (201) 673-1860. We believe you'll be impressed with modern rehabilitation medicine.



New Jersey Rehabilitation Hospital

Owned and operated by Madencare Centers of America, Inc.

240 Central Avenue, East Orange, NJ 07018 • 201-673-1860

Bertrand J. Bensam, MD, Medical Director • Stanley Shepard, Administrator

Accredited by the Joint Commission on Accreditation of Hospitals, the Commission on Accreditation of Rehabilitation Facilities and the American Board for Certification in Orthotics and Prosthetics Inc.

Information for Readers and Contributors

The Journal, the official organ of the Medical Society of New Jersey is published monthly under the direction of the Committee on Publication. Released the first week of the month, a copy is sent to each member of the Society. The goals of *The Journal* are educational and informational. All material published in *The Journal* is copyrighted by the Medical Society of New Jersey.

CONTENT

The educational content of each issue appears as original *scientific articles*, based on research, original concepts relative to epidemiology of disease, and treatment methodology; *case reports*, based on unusual clinical experiences; *review articles*; *clinical notes*, succinct items on some aspect or new observation or technique of a case experience; and *special articles*, which may include evaluations, policy and position papers, and reviews of non-scientific subjects. Material submitted here is for exclusive publication in *The Journal*. Upon request of the author, the Committee on Publication may give permission to authors of original material to reprint articles elsewhere with appropriate credit to *The Journal*. The principal aim in the preparation of contributions should be relevance to diagnosis and treatment and to education of patients and professionals. Preference will be given to professional authors from New Jersey and to out-of-state lecturers who submit a suitable manuscript based on a presentation made in New Jersey.

ASSIGNMENT OF COPYRIGHT

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978) a transmittal letter or a separate statement accompanying material offered to *The Journal* of the Medical Society of New Jersey must contain the following language and must be signed by all authors:

"In consideration of *The Journal* of the Medical Society of New Jersey taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *The Journal*, MSNJ."

Individuals, universities, libraries, and other non-profit organizations will be permitted to photocopy articles in *The Journal* for non-commercial, educational purposes.

SPECIFICATIONS

Manuscripts—Manuscripts must be typewritten double-spaced on 8-1/2 by 11" paper with margins of at least one inch. The original and one copy should be submitted to the Editors. Authors must understand that the material submitted is for the exclusive use of *The Journal* and will not be published elsewhere except in abstract form or with the consent of the Committee on Publication. Statistical methods used in articles should be identified. Acknowledgments of aid in preparation of manuscripts will not be made, except for specific preparation of an essential part of the manuscript (such as statistical data or special photographs).

Tables and Illustrations—Tables must be typewritten, double-spaced on separate 8-1/2 by 11" sheets. Each table must have a title and number. Symbols for units should be confined to column headings, and abbreviations, properly explained, should be kept to a minimum. Illustrations or figures should be of professional quality black-and-white

glossy prints. They should be unmounted and not damaged by staples or paper clips. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. Where photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source; written permission for republication from the original publisher must be submitted. The cost of color photographs must be borne by the author.

Title Page—The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests should be sent.

Summary—The summary of the article should not exceed 250 words. It should contain the essential facts in such a form as to be understandable without reference to the text. Meticulous writing of this section is essential.

Abstract—The author should submit a 50-word abstract to be used at the beginning of the article.

Drug Names—Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

References—References, which should not exceed 35 citations except in review articles, should be cited consecutively in the text by numbers in parentheses at the end of the sentence. The reference list should be typed double-spaced on separate 8-1/2 by 11" sheets in the numerical order in which they are first cited in the text. The style of references is that of *Index Medicus*.

Examples:

Goldwyn RM: Subcutaneous mastectomy. *J Med Soc NJ* 74:1050-1052, 1977.

Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969, pp. 00-00.

Accident Facts. Chicago, Illinois, National Safety Council, 1974.

PUBLICATION POLICY

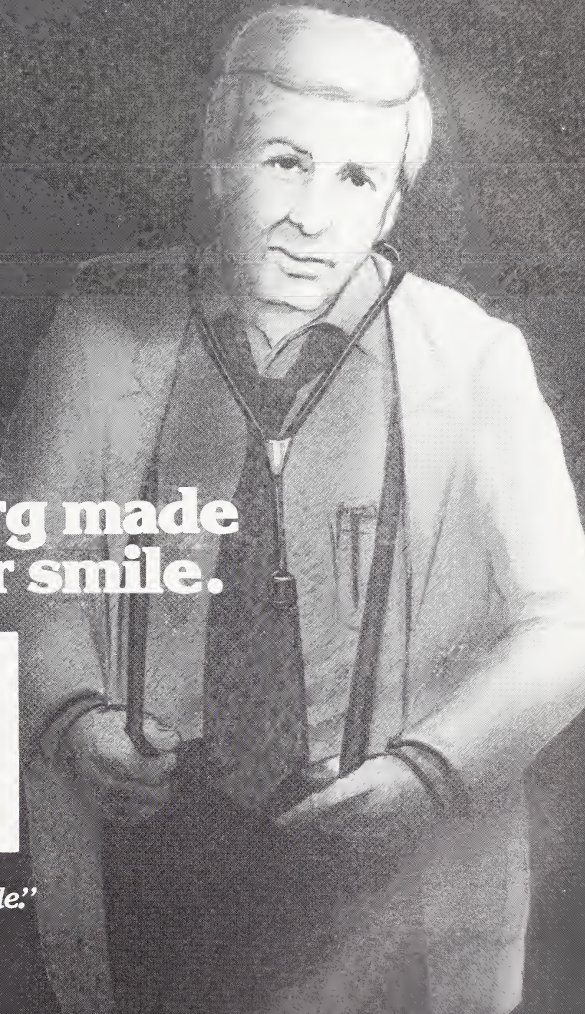
Receipt of each manuscript will be acknowledged and a copy delivered to the Editor who refers the paper to one or more members of the Manuscript Review Board, who render an opinion to the Editor. The final decision is reserved for the Editor. No direct contact between the reviewers and the authors will be permitted, but authors will be informed of the reviewers' comments. The publication lag for original articles may be six months or more. Galley proofs will be submitted to the author for correction of typographical errors. Editorial changes which are made in the interest of clarity or good grammar may not be altered by the author. Reinsertion of redundant material deleted by the Editor is not permitted.

REPRINTS

Reprints may be ordered after the author is notified that his article has been selected for a specific issue of JMSNJ. A check for the cost of reprints including remake charge if order is received after due date must accompany the order.

COMMUNICATIONS

All communications should be sent to the Editor, *The Journal*, MSNJ, 2 Princess Rd., Lawrenceville, N.J. 08648.



**At 4:25 PM
mild mannered
Mindy Sternberg made
a harried doctor smile.**

Mindy is part of our special Blue Shield professional relations staff. Mindy and her colleagues specialize in answering physicians' questions. You can depend on our professional relations staff for quick answers to your questions regarding claims, billing information, and contract interpretation.



***"It's our job to
make things simple."***

In addition, professional relations staff members handle the enrollment of new participating physicians, and the training of medical assistants.

So, next time you run into a Blue Shield related problem, call on us for the answer.



**Blue Shield
of New Jersey**

Featuring: Preemployment Examination and the MD's Duty to the Public

Many internists and family practitioners routinely conduct detailed medical histories and physical examinations of prospective employees for companies in the community. In the vast majority of cases this is a simple matter. The patient is examined, the doctor completes the appropriate form and the company reviews his findings to decide whether there is a medical reason not to hire him. Few physicians worry about their liability exposure, should they fail to discover a significant handicap in a new employee who later causes legal harm to the company. But a recent decision by the Supreme Court of Tennessee, *Wharton Transport Corporation v. Bridges* 606 S.W. 2d 521 (1980), suggests that they should.

In *Wharton* a trucking company brought an indemnity action against the doctor who had examined a new employee and certified him as fit to operate a truck on long-distance hauls. On his solo run the employee pulled off a highway late at night and rammed into a parked automobile, injuring three persons and killing one. The trucking company eventually settled lawsuits brought against it for \$426,314.

During the course of that litigation the company learned that the real physical condition of the driver was substantially less than had been indicated by Dr. Bridges. Another physician who examined the driver and reviewed his medical records testified that: (1) he had chorioretinitis in both eyes with ninety-five percent loss of vision in his left eye, blurred vision in his right eye and reduced depth perception, (2) he had severe osteoarthritis in his left knee and a functional debility in his right leg that qualified as a "thirty percent disability to the body as a whole," (3) he had chronic degenerative disc disease with reduced range of motion in his neck and (4) he was suffering from depression. The expert witness testified that the driver had qualified for a one hundred percent disability five years prior to this employment. None of these problems had been noted by Dr. Bridges on the employment forms.

When the company sued the doctor he admitted that under the ICC regulation (with which he was familiar) the driver's visual defects alone disqualified him from working as a trucker. He also admitted that a physician acting with reasonable care would have discovered the various physical defects. Nevertheless, the trial judge directed a verdict in favor of Dr. Bridges. The ensuing appeal focused on the question of *proximate cause*. The trial judge had relied on evidence that just prior to hitting the automobile the trucker had taken his eyes off the road. If this was true, he argued, then it did not matter whether Dr. Bridges had failed to discover the driver's bad eyesight. The Court of Appeals agreed, writing: "Is there any proof that the inattentive driving was caused by the faulty eyesight? It seems to us to make little difference how many eyes you have, if what you have is looking down toward the floor board instead of the road ahead."

The Supreme Court disagreed. Proceeding from the rule that in reviewing the directed verdict they must take the strongest possible view of the plaintiff truck company's arguments, the judges ruled that the physician's failure to discover disabilities that might significantly limit one's ability

to drive could be the "act of omission which immediately causes or fails to prevent the injury." The judges were heavily influenced by the fact that Dr. Bridges performed these preemployment physicals for many trucking firms and that he was very familiar with the requirements for employment. On that basis they found that the physician should reasonably foresee that his failure to detect disabilities could lead to injuries to motorists. The court concluded: "We are not attempting to make the physician an insurer of highway safety, but his duty to properly conduct the physical examination extends beyond his contractual responsibilities to the driver and the trucking company." The case then was remanded for trial so that the trucking company could try to prove that the doctor had violated his duty.

This case seems to open a Pandora's box. How far might the potential liability of the examining physician be extended? Should a physician be liable for the consequence of an air crash if he fails to discover a personality disorder in an air traffic controller? What if he fails to diagnose a mild hearing defect in an employee who must operate dangerous machinery which uses warning buzzers? Unfortunately this case suggests that the preemployment physical always may not be so routine for the physician. I would advise all physicians carefully to question their patients about the proposed employment and to give special attention to those involved in potentially dangerous occupations. Phillip Reilly, J.D., M.D. from *Medical Liability Monitor*, September, 1981, Vol. 6, No. 9 (formerly the *Malpractice Lifeline*).

PHYSICIAN ALERT

Changing Indications for Splenectomy—A study of patients who have undergone a splenectomy during the past 30 years resulted in a "recommendation that patients who exhibit thrombocytosis in the postoperative period should be considered for treatment with low-dose antiplatelet drugs."

The study conducted by the Department of Surgery at Ohio State University was summarized in the August 3 issue of *Personal Injury Newsletter*, a law publication of the Matthew Bender and Company.

Of the 2417 cases reviewed 999 included splenectomies for hypersplenism (41 percent), 659 incidental to other abdominal procedures (28 percent), 257 in the treatment of traumatic injuries (10.5 percent), and 203 staging laparotomies for Hodgkin's disease (80 percent). Thirty-four percent of the patients had one or more postoperative complications, and mortality was nine percent. Four hundred seventy-three of the patients had undergone a splenectomy during the past five years. "This group was compared with the entire series to identify changing trends in the indications for splenectomy." The results of this comparison were:

*This item, from the Department of Professional Liability Control, MSNJ, was prepared by James E. George, M.D., J.D., and A. Ronald Rouse, who are, respectively, Director of the Department and Assistant Director and Editor.

(a) "Staging laparotomy for Hodgkin's disease represented 27 percent of the splenectomies performed. Incidental splenectomy in association with upper abdominal surgery comprised 20 percent of the study group, whereas splenectomy for hypersplenism had decreased in frequency by 29 percent to 16 percent. The overall complication rate during the last five years decreased from 39 to 15 percent, and mortality fell to six percent."

(b) "Recent recognition of the increased risk of complications after incidental splenectomy and the documentation that splenectomy results in a lifelong immunological deficit in adults as well as in children has tempered enthusiasm for incidental splenectomy. In a previous report of 564 cases of patients undergoing incidental splenectomy, complications occurred in 44 percent, and postoperative death occurred in 14 percent. During the recent five years, 93 patients underwent incidental splenectomy with a morbidity of 26 percent and mortality of 12 percent. While there is a decrease in the number of splenectomies performed incidental to other procedures, it is important to recognize that the complications continue to be excessive (32 percent morbidity, 14 percent mortality for the entire series). Subphrenic abscess contributed heavily to the complications."

(c) "Thrombocytosis (platelet count >400,000/cu mm) was observed in 47 percent of all patients postoperatively. Thromboembolic complications occurred in three percent. Such complications occurred in six percent of 223 patients who had elevated platelet count in the recent five-year study, and in only 0.4 percent of 250 patients with platelet counts less than 400,000 platelets per cubic millimeter. Patients with increased platelet counts after splenectomy are at greater risk than patients who maintain normal platelet counts."

DID YOU KNOW

... Lawyers account for 45 percent of the New Jersey Senate membership (18 of the 40) and nearly 25 percent of the Assembly (19 of the 80).

... An independent actuary, hired by the New York Superintendent of Insurance, has added to the already cloudy issue of a premium increase for physicians of New York by proposing a 107 percent increase. MLMIC, the physician-owned company, proposed a 71 percent increase, but later reduced this to 52 percent when a collateral source bill was signed into law. The state's Joint Underwriting Association has requested 367.8 percent. The Suffolk County Medical Society has an advisory filing which concluded that a rate of not more than five percent was warranted. All of the proposals were developed by separate actuary studies.

... The *American Medical News* (10/9/81) has reported British physicians as facing a 12½ percent increase in their professional liability insurance premiums. The increase would be approximately \$245, as opposed to the average U.S. malpractice premium of \$5100. Interestingly, Britain's House of Lords has ruled that errors in judgment are not necessarily negligence.

... An Army Nurse has received a settlement which could amount to \$60 million if her severely brain-damaged child survives until age 72. The mother brought a suit against the U.S. Army's Tripler Army Medical Center in Honolulu, claiming her infant's skull was fractured "when an anti-

quoted suction method of delivery was used instead of forceps." The out-of-court settlement, the largest ever reached by the Army, provided for a payment of \$95,000 a year for the care of the institutionalized child. The mother received an additional \$655,000.

... The U.S. government, in its investigation of soaring health costs, reports malpractice insurance as being responsible for about six percent of health care bills.

FREE AMNIOCENTESIS BOOKLET FOR PROSPECTIVE PARENTS

The Department of Professional Liability Control has a quantity of booklets entitled, *Amniocentesis for Prenatal Chromosomal Diagnosis* prepared by the Center for Disease Control. Physicians may request free copies through the Department at MSNJ, 2 Princess Road, Lawrenceville, NJ 08648 or by phoning an order through A. Ronald Rouse at (609) 896-1766.

MIENJ OFFERS A CHANCE TO CATCH UP

If your malpractice insurance limits were less than a million dollars at any time during the last ten years, you may have a recurring sense of peril when you read about a just-awarded \$1,000,000 verdict against a doctor who treated a patient in 1972. In 1972 you carried malpractice insurance limits of only \$100,000/300,000. What happens if a claim surfaces now from that old year, that is more than the coverage you had then? Up until today all you could do was reassure yourself that, if faced with an underinsured judgment of that proportion, you always could declare bankruptcy. The details of the bankruptcy route aren't clear in your mind and the prospect of selling all your family's assets and prostrating yourself before some judge isn't very comforting. Awards and verdicts continue to escalate every year. The protection of any reasonable statute of limitations in New Jersey on old claims has been stripped away. New methods of successfully suing doctors are being talked about all over the country. Wrongful life, wrongful death, genetic counseling, informed consent, ad infinitum. If someone perceives that he has been wronged by the system, a resourceful attorney will find a way to get part of your hard-earned savings.

Your worries on this issue soon may be over. The Medical Inter-Insurance Exchange of New Jersey has designed and plans to market a policy to fill the gap between the low limits you had and \$1,000,000. This is an unique product never before available. The Exchange is asking the approval of the New Jersey Department of Insurance before it begins to sell the protection. Preliminary information is that the "catch up" policy will go back a maximum of ten years. The price will be based upon how many years you had limits below \$1,000,000. Claims which already have been reported naturally will not be covered by the new policy. An open enrollment period is planned after details have been finalized. If you are at risk due to low limits of insurance and are interested in the new policy, call the Exchange at (609) 896-2404 to be put on the mailing list. This certainly will be your last chance.

IF YOU'RE USING LORAZEPAM
TO TREAT ANXIETY-
SOME THINGS ARE MISSING...





MIND AND MUSCLE CONCERT OF ACTION

...distinct antianxiety and skeletal muscle relaxant actions to ease tense emotions and relax tense muscles.

...rapid absorption and a built-in tapering effect through active metabolites, for smooth transition to independent coping.

...a history of clinical experience and safety unequalled by any other benzodiazepine.

PREDICTABLE I.V. SPAN OF ACTION

With I.V. Valium you get predictably brief anterograde amnesia, usually lasting 20-60 minutes.¹ With I.V. lorazepam, sedative and amnesic effects may last 8 hours or even longer. Even orally, sedation and impairment of motor skills may last significantly longer than those of Valium.^{2,3}

Of course, with all benzodiazepines—caution patients against immediate resumption of activities requiring complete mental alertness, such as driving. Ingestion of alcohol should be avoided.

References: 1. Data on file, Hoffmann-La Roche Inc. 2. Seppala T, et al: *Br J Pharmacol* 3:831-841, 1976. 3. Harry TVA, Richards DJ: *Br J Clin Pharmacol* 26: 371-373, 1972.

VALIUM[®] ^{IV}

diazepam/Roche

Tablets: 2-mg, 5-mg, 10-mg scored tablets
Injectable: 2-ml Tel-E-Ject[®] disposable syringes } 5 mg/ml
2-ml ampuls, 10-ml vials }

Please see summary of product information on following page.



**VALIUM® (diazepam/Roche)
TABLETS AND INJECTABLE**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome.

Oral form may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus, anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures, cardioversion.

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age, known hypersensitivity, acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been reported with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of pre-disposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients, should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V., inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions; drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest, concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have restrictive facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/2, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs. Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use. Efficacy/safety not established in neonates (age 30 days or less), prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence, can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam/Roche), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount; in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2 1/2 mg once or twice daily, increasing gradually as needed or tolerated).

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Miscellaneous: Although promptly controlled, seizures may return; re-administer if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures, use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug. Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam/Roche) therapy and are of no known significance.

Miscellaneous: Venous thrombosis/phlebitis at injection site, hypocoagulation, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperperistalsis, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V. fluids, adequate airway. Use levatereno or metaraminol for hypotension. Dialysis is of limited value.

Michael R. DeVita, M.D.
announces the opening of
**PASCACK VALLEY
FERTILITY INSTITUTE**
For the management of all
phases of Human Infertility

Female
Male
Microsurgery
Inquiries Invited

221 Old Hook Road
Westwood, N.J. 07675
(201) 666-4115



KATE MACY LADD
CONVALESCENT HOME
Far Hills, N.J.

*Under the terms of the Will of the late
Walter G. Ladd we provide*

**"Skilled Convalescent Care
Without Charge"**
To
Ambulatory Female Patients.

Inquiries to:
Newark Office—744 Broad St.
Newark, N.J. 07102
For all information
Tel: (201) 622-1484
Over 20,000 admissions
since 1949

Barry L. Mills, FACNHA, LNHA
Administrator
Don T. Van Dam, M.D., DABFP
Medical Director

Competition in Medicine—The New Strategy

"Appearances often are deceiving."
Aesop "The Wolf in Sheep's Clothing"

The recent rash of articles concerning "competition in medicine" gives an impression that its proponents have been able to develop a solution to the problem of escalating medical costs.^{1,2} The significance of these proposals demands our attention and critical judgment.^{3,4}

The authors of this concept are proposing a variety of health insurance packages which, in order to be federally qualified, must contain specified medical benefits. They will also determine how much untaxed money the employer will be allowed to contribute to a qualifying program. Those workers who wish to purchase health insurance policies which will include additional benefits and which cost more than the amount allowed, will have to pay the difference from their own pocket with after-taxed dollars. These health-cost planners have not disclosed the conditions under which the larger federally controlled subscriber groups (Medicare and Medicaid patients) will be served by these programs.

After having arbitrarily set such predetermined amounts of tax-free dollars and qualifications for specified medical services, will the government then allow the "forces in the marketplace" to achieve a containment over increasing medical costs through the "healthy and natural process of unrestricted competition"?

We, in medicine have been nurtured on and have accepted the concept and the intrinsic benefits of "competition for excellence" and "competition among ideas" in eliminating disease. However, this medical program is a horse of another color and is only masquerading under the blanket of "competition." What will be in competition are the major insurance companies, HMO organizations (many of which are government funded), and Blue Cross Plans. The principal beneficiary of this multiplicity of insurance services ultimately will be the insurance industry itself, and not the public.

In this new system, these health insurance companies must develop mechanisms to control successfully the cost of the premiums charged to subscribers. Their fiscal requirements may include full fee acceptance by participating physicians in the various programs as well as strict administrative regulation of medical services. The success of this competition will be measured by the cost of medical care. The winner of this "competition in medicine" contest will be that insurance company which best can package and market the least expensive insurance policy. This type of competitive environment is not likely to enhance the quality of medical care or the concern for the patient.

In the case of an HMO-IPA, the doctors who have joined to provide medical services to the HMO subscribers, volun-

tarily have assigned to the IPA the right to define both the quality of medical care and the proper utilization of the diagnostic and treatment services rendered to its subscribers. These conditions, in effect, totally will control the office and hospital practices of the medical providers when treating the HMO subscribers. These IPA doctors also have agreed to maintain and to share the subscriber's medical records upon the request of the HMO. At the same time these medical providers (formerly known as physicians) also have become partners at risk in the HMO venture by agreeing to have a portion of their fees withheld by the HMO. The medical providers also have agreed to obtain prior approval of the HMO before admitting the HMO subscriber to a hospital, in order to reduce hospital utilization.

Those who have written the most about this plan to introduce "competition into medicine" and who are its strongest supporters are our economists and social planners, together with our elected legislators and lawyer friends. Noticeably lacking in this strategy are those whose services will be peddled by the insurance marketing departments, the physicians themselves. Most discussions of this new strategy merely describe the mechanics of these insurance programs and how the dollars spent should fit in with a manipulation of our tax laws. Regardless of how this medical insurance salad is mixed, the principle that "if you pay less, you will get less" still is valid.

How the physician fits into and is affected by this proposed scheme never is mentioned. If the doctor allows himself to be defined by the legislators, economists, social planners, lawyers, and labor leaders it will be because he has lost sight of his own image. This will occur if he voluntarily allows himself to function merely as a medical provider (one of many technicians who provide graded levels of technical competence) and becomes locked economically into the controlled administrative patterns of various competing medical insurance programs. The physician then will awaken to find himself truly in competition with his medical colleagues and in an environment quite foreign to his accustomed professional role.

Each county medical society should appoint a study committee which will focus upon the implications of this proposed strategy of competition. These groups of practicing physicians should consider this program in the broadest social, medical, economic, and political terms. This evaluation should include what "competition in medicine" will mean to all patients, rich and poor, to hospitals of the community and teaching types, and to physicians, especially those in independent, private practice. A thoughtful analysis is required to show the influence and control which could be exerted by the insurance companies upon our medical prac-

tices along with a projection of the increased governmental capability in structuring and administering this "competitive medical system."

Now is the time for enlightened and concerned physicians to show whether they are capable of conducting themselves as members of a profession in a socially responsible fashion. If a consensus is achieved it must be broadly distributed, clearly and forthrightly, to the public—our patients—so that they may know, and then can judge! Albert Minzter, M.D.

References

- ¹Enthoven AC: The competition strategy: Status and prospects. *N Engl J Med* 304:109-114, (Jan. 8) 1981.
²Caper P: Competition and health care. *N Engl J Med* 304:1296-1299, (May 21) 1981.
³Correspondence: Competition in health care. *N Engl J Med* 304:1240-1241, (May 14) 1981.
⁴Health Insurance Association of America: Competition in the Health Care System, March 1981.

See Commentary on page 911

The Future of Medicine in the Eighties

Having lived through six decades and practiced medicine for three, I am tempted to try to predict what is going to happen to our profession in the next decade. Each of these predictions brings up a question or a challenge that must be answered. The answers to these questions will determine the quality of medicine we will practice in the 1980s.

INCREASED LONGEVITY

There is no doubt that people are living longer. We are a part of an aging population. Each year sees more oldsters and fewer youngsters. One of my patients pushing 100 said to me recently, "I'm not too fond of the 90s!" On one end of the spectrum the fertility rate is down because of "the pill," the IUD, abortion, and the voluntary decision of many young people not to have large families. On the other end of the spectrum, people are aging because they are getting better medical care. I heard of a man at 92 who said, "If I knew I was going to live this long, I'd have taken better care of myself." Patients with heart attacks are being saved; hypertension is being treated; cancer therapy prolongs many lives. I see many patients now who live with their cancer and die with something else.

The problem this raises is: How can we handle an aging population, with fewer people working to pay social security benefits for the elderly? With decreased growth in the reserves, do we increase the tax on those receiving benefits, raise the retirement age, or cut down on the benefits? I am convinced that we need no increase in hospital beds, but we should have more long-term custodial beds, and more home health-care benefits, such as "aunts and uncles for the elderly" or "elder" sitters. There probably will be an increase in the use of mind-altering drugs to prevent senility. *OMNI* magazine, in May 1979, listed fourteen chemicals that promote intelligence, some of which we use now (such as Hydergine®, Lecithin®, Choline®, amphetamines, Dilantin®, and Ritzlin®).

INCREASED SELF-CARE

America is beginning to find the answer to preventive medicine by getting people involved in their own health care. There are all kinds of plans which foster increased exercise, fewer calories, less drinking, and abstinence from smoking. Blue Shield of New Jersey passes out a book called "Take Care of Yourself." The president of Johnson and Johnson

said his first priority for the 1980s was to promote the health of his work force. It is widely accepted that the most common nutritional problem of adults in the United States is obesity and the gravest drug problem is alcohol.

Americans in the next decade undoubtedly will take better care of themselves and be more aware of their bodies. In turn, they will become more involved in and take more responsibility for their own health care. In October, 1980, Marshall Field Company started home health-care departments that offer several types of blood-pressure testing devices, stethoscopes, otoscopes, and dental reflectors. They even have licensed fitters to select the proper traction equipment! I have a feeling that in the 1980s people will exercise more, smoke less, drink about the same, and still try out all kinds of absurd diets. They will have more knowledge of their own health records, what medicine they are taking, and various ways to save their own lives (such as CPR, the Heimlich Maneuver, Vial of Life, Medic-Alert, and Telmed). They will become more involved in socio-medical decisions that affect them, such as abortion, euthanasia and radiation exposure from atomic energy plants, as well as from hospital and dental radiation equipment.

With all this self-help there arise two potential dangers. First, there may be a tendency for individuals to become less involved with others in their family, and second, people may go overboard with various types of holistic medicine, i.e., techniques of therapy that attempt to treat the whole body, but fail to cure diseases or repair damaged organs. There are some specific modalities (such as hypnosis, acupuncture, and transcendental meditation, the ultimate goal of which is immortality) that have a place in special circumstances, but may become dangerous if they become a cult. Dr. Elizabeth Kubler-Ross of *Death and Dying* fame, once asked an audience if they really would want to live for 35,000 years. A man in the back row yelled, "What, with the same woman?" Only two of our presidents have lived to the age of 90 (John Adams and Herbert Hoover), but a man who is eligible for Medicare this year can expect to live to 79 and a woman to 83!

INCREASED EFFORTS TO CURB HEALTH COSTS

There have been, and there will be, coercive attempts to cut costs at the risk of lowering quality or to reduce services or to ration care. Let me mention five of these coercive

measures: the first is being tried in New Jersey—a scheme to pay hospitals a specified amount for a specific illness. It is called the DRG system—a listing of 383 “diagnosis related groups.” For example, a hospital will be reimbursed \$909 to take care of a patient with diabetes if he is less than 36 years of age; if he is over 36, the hospital will be paid \$1012; if he has surgery, \$1698. It is an effort to cut down on the length of stay, and get patients out of the hospital faster. A second method of coercion is to require second opinions. In January 1980, Governor Byrne signed a bill mandating the insurance companies of New Jersey to offer this service. Another method is a scheme of prepaid medical care called the Health Maintenance Organization (HMO) or the Individual Practitioners Association (IPA). These groups accept patients at a certain annual fee, but are at risk if the care given these patients costs more than they bargain for. One of the most dangerous attempts to get more for less cost is the use of midwives and physicians’ assistants, individuals who have less training and less expertise to do the tasks of a physician. The fifth and most dangerous means of controlling the cost of health care is to ration that care to those who “deserve to live”—in effect, monetary euthanasia. There is a gradual reluctance of insurance companies to pay for repeated hospitalizations of the alcoholic who won’t stop drinking, or the heavy smoker who is dying of emphysema. In my opinion, this takes away the “quality of mercy,” and makes those who advocate this absence of care as guilty as the priest and Levite who “passed by on the other side.”

There are logical methods to control health care costs that work. In the late 1970s, President Carter’s bill to put a cap on hospital costs stimulated the voluntary effort of the American Hospital Association and the American Medical Association, which saved the American people over two billion dollars in two years. There are other voluntary methods that are effective. Many insurance companies pay for preadmission testing, a method whereby patients can have their laboratory tests and x-rays done prior to admission, and thus save valuable hospital days. In some states, Blue Shield pays for certain surgical procedures done in an outpatient setting (such as hernia repairs, breast biopsies, and minor gynecological procedures). Lastly, doctors are learning to stop ordering repeated laboratory tests, x-rays, and electrocardiograms.

Because of the fear of an unacceptable rise in health costs, I feel there will be no push for socialized medicine or national health insurance in the eighties.

MORE FAMILY DOCTORS

A recent governmental report predicted that there will be 70,000 too many doctors in 1990, and 145,000 too many in the year 2000! If this is true, how will doctors practice in the next decade? I feel there will be fewer specialists, and more primary care physicians—doctors who are willing to treat sick patients when they’re sick. A recent report said that “current statistics show that by 1985, 85 percent of Americans will have one physician providing continuing care for

most general medical problems.” I think that doctors of the future will spend more time with their patients in listening, teaching and counseling, and will use fewer drugs. With the predicted surplus of physicians, there undoubtedly will be more competition and success in practice will go to those who are the most ethical and care about the quality of care they give. More physicians will retire early, or limit their type of practice. The cost of malpractice insurance will remain high as long as mistakes are made and lawyers see a potential suit. Inside the profession, doctors will be more willing to police themselves. Continuing medical education will be encouraged, and mandated in some states. The battle over recertification of specialists will continue and the American Board of Family Practice will continue to require a recertification examination every six years. With all this, there will be more paperwork, but doctors’ writing will not improve.

INCREASED TECHNOLOGY

The 1970s saw the advent of stress-testing, pacemakers, ultrasound techniques, radioisotopes for diagnosis, cobalt radiation for cancer therapy, and lens implants done as outpatient surgery. The inventor of computerized axial tomography (the CAT scan) was awarded the Nobel Prize in medicine as the greatest advance in x-ray since its discovery in 1895 by William K. Roentgen. The 1980s will see advances in newer noninvasive diagnostic techniques. There is now a dynamic spatial reconstructor which provides a three-dimensional video image of organs, with muscle tissue electronically removed, leaving only branching blood vessels on the screen. The only problem is—it costs \$5,200,000! We now have the means of doing biochemical blood levels and outpatient cardiac biopsies. Transthoracic pacemakers have appeared on the market. There will be further attempts at transplants of all kinds, and, for the first time in this country, test-tube babies. Dr. Michael E. Debaque, the Texas surgeon who did the first heart bypass in 1964, predicted that a million patients will have had this operation by 1985.

With all these advances in technology, there will be more decisions on the proper use made by nontechnologists and by potential beneficiaries of these techniques.

The final question is: “Will it all be worth it? Are we right in striving to achieve the best in the field of health care?” Let me answer this with a poem by R.L. Sharpe quoted by the famous heart surgeon from Houston, Dr. Denton Cooley, in an article he wrote discussing heart transplants:

*Isn't it funny that princes and kings
And clowns that caper in sawdust rings
And simple folks like you and me
Are builders for eternity?*

*To each is given a bag of tools,
A shapeless mass, and a set of rules,
And each must make, 'ere life is done,
A stumbling block or a stepping-stone.*

John S. Madara, M.D.

"Hopefully" Will Disappear—I Hope!

It is difficult to edit manuscripts without being pedantic because the quality of the syntax may be poor enough so as to make the scientific and medical context of the article suffer. A particular case in point is the use and abuse of trite expressions and medical jargon.

Unfortunately, certain words and expressions have a habit of appearing in almost every article and, unfortunately, they also have been used in verbal presentations so often as to appear to be contagious from one speaker or writer to another.

Many examples of this universal problem are available. These appear in all medical writing including correspondence, hospital charts, interpretations of x-rays and electrocardiograms and in case presentations, as an assault on the eye on the ear. The following few will suffice, but emphasis is placed on one.

WORK-UP

Why do we use work-up rather than work-down? This probably is the most abused expression in all case reports. The author wishes to speak about the evaluation of the patient by means of history, physical examination, laboratory tests and x-rays. Why not look for alternative words or expressions, including analysis, investigation, evaluation, assessment, appraisal, assay or others?

CASE

Too often patients are dehumanized by being referred to as a "case of diabetes" or a "case of squamous cell carcinoma." Patients are people with health problems not cases. It reads and sounds better to refer to a person or patient with diabetes.

PRESENTED

"The patient presented with chest pain, shortness of breath. . . ." This conjures up an image of an individual who popped into an emergency room carrying boxes labeled "chest pain," "shortness of breath," or whatever.

Would not the patient *complain* of chest pain or shortness of breath?

HOPEFULLY

And now for the real purpose of the diatribe—"hopefully." It is almost impossible to listen to a political speech, a press conference, a radio or television interview or an ordinary conversation without hearing at least one and often several sentences begin with "Hopefully, . . ."

The following concise exposure of the misuse of "hopefully" by Strunk and White may convince those who read it to modify their own writing and speech.

"Hopefully. This once-useful adverb meaning 'with hope' has been distorted and is now widely used to mean 'I hope' or 'It is to be hoped.' Such use is not merely wrong, it is silly. To say, 'Hopefully, I'll leave on the noon plane' is to talk nonsense. Do you mean you'll leave on the noon plane in a hopeful frame of mind? Or do you mean you hope you'll leave on the noon plane? Whichever you mean, you haven't said it clearly. Although the word in its new, free-floating capacity may be pleasurable and even useful to many, it offends the ear of many others, who do not like to see words dulled or eroded, particularly when the erosion leads to ambiguity, softness, or nonsense."*

I hope that "hopefully" and "work-up" will disappear from our manuscripts. A.K.

*Strunk, W. and White, E.B.: *The Elements of Style*. New York, MacMillan, 1979, p. 48.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. Drug Therapy, Sept. 1975. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® 5^{Buccal} / 10^{Oral} / 25^{Oral}
mg. mg. mg.

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



KESSLER INSTITUTE FOR REHABILITATION

West Orange, New Jersey

*Affiliated with the College of Medicine and
Dentistry of New Jersey*

A voluntary, non-profit specialty hospital founded in 1949 serving physically handicapped children and adults. Intensive and comprehensive medical services are provided to inpatients and outpatients; services include social, psychological and vocational services for patients with spinal cord injuries, stroke, amputations or any physical impairment due to congenital condition, accident or disease.

Total facilities include a 76-bed inpatient wing; separate outpatient department; complete hydrotherapy unit; complete speech and audiology services; comprehensive outpatient amputee and urological services.

Fully accredited by the Joint Commission on Accreditation of Hospitals and the Commission on Accreditation of Rehabilitation Facilities.

Provider of hospital services under Medicare and Medicaid.

* * * *

**ADMISSION BY MEDICAL REFERRAL TO
DIRECTOR OF ADMISSIONS**

* * * *

**RICHARD A. SULLIVAN, M.D., Medical Director
KENNETH W. AITCHISON, Executive Director**

Telephone: (201) 731-3600

a group Blue Cross/Blue Shield plan for doctors

Officially Endorsed by The Medical Society of New Jersey

**BROAD COVERAGE
COMPETITIVE RATES**

For More Information Contact

Donald F. Smith and Associates

1 Airport Place, Route 206 North, P.O. Box 2197 • Princeton, New Jersey 08540 • (609) 924-8700 or (201) 622-6046

Underwritten by New Jersey Blue Cross-Blue Shield

JEMPAC STRIVES TO INCREASE MEMBERSHIP

During 1981 some 320 physicians and their spouses became members of JEMPAC, down 43 percent from the previous year's alltime high of 571. Despite the limited membership, JEMPAC managed to contribute approximately \$18,000 to legislative and gubernatorial candidates.

John J. Smith, Jr., M.D., chairman of AMPAC, forecasts the 1980s as bringing sweeping changes, "and we must play a major role . . . we must be able positively to influence the decisions made." JEMPAC has echoed these sentiments repeatedly to the physicians of New Jersey. Unfortunately only a few physicians have managed to understand the importance of physician involvement in the political process. JEMPAC is most appreciative of the interest and support it has received from the three percent of MSNJ's membership, and particularly acknowledges those 61 who have elected to become sustaining members.

Bergen County: Alfred Alessi, M.D., Arthur Goldfarb, M.D., Mr. Joseph Klein, Edward Luka, M.D., Paul Megibow, M.D., Richard Roukema, M.D., Harold Scales, M.D., James Todd, M.D., Robert Verdon, M.D.; **Burlington County:** Meyer Abrams, M.D., James Pegues, M.D., Charles Krueger, M.D.; **Camden County:** Nathan Asbell, M.D., Frederick Durham, M.D., Young Lee, M.D.; **Cumberland County:** Jeffrey Solomon, M.D.; **Essex County:** Anthony Caggiano, M.D., Robert Lorello, M.D., Charles Nadel, M.D., Arne Skillbred, M.D., John Thompson, M.D., Carolyn Watson, M.D., Frank Watson, M.D., Robert Weierman, M.D.; **Gloucester County:** Armando Goracci, M.D.; **Hudson County:** I.L. Chanan, M.D., Thomas Connolly, M.D., Charles Cuniff, M.D., Carl Restivo, M.D.; **Mercer County:** Karl Franzoni, M.D.; **Middlesex County:** Victor Boogdanian, M.D., Palma Formica, M.D., Bernard Rineberg, M.D., Howard Slobodien, M.D.; **Monmouth County:** William D'Elia, M.D., Edward Schauer, M.D., Thomas Witomski, M.D., Joseph Woolwich, M.D.; **Morris County:** Augustus Baker, M.D., Henry Liss, M.D., Myles Morrison, M.D., Catherine Spears, M.D.; **Ocean County:** Blackwell Sawyer, M.D.; **Passaic County:** Harry Dawson, M.D., Richard E. Lang, M.D., Hervey Sicherman, M.D., Irving Weiss, M.D.; **Salem County:** John Madara, M.D.; **Union County:** Douglas Costabile, M.D., Alexander Kovacs, M.D., Henry Mineur, M.D., Roland Roecker, M.D., Frank Romano, M.D., Mrs. Phyllis Romano, Gerald Schoenbrun, M.D., Richard Sharrett, M.D., Anthony L. Spirito, M.D., Anthony M. Spirito, M.D., Errol Warner, M.D.; **Sussex County:** Alden Hall, M.D.; **Non-Member MSNJ:** Alan Saroff, M.D.

Armando Goracci, M.D., President of the Medical Society of New Jersey, and Alan Scher, M.D., President of the Association of Medical Society Specialties assisted JEMPAC in its 1981 membership drive through letters of appeal to members of MSNJ. The greater the membership in JEMPAC, the greater the impact on legislation affecting the professional and private lives of physicians.

JEMPAC CONTRIBUTIONS/TAX CREDIT

Federal law provides a tax credit equal to one-half of a

political contribution with a maximum credit of \$50. Consequently, physicians who are members of JEMPAC may file a tax credit for \$15 if they are active members, and \$25 if sustaining members.

MOTHS, WEEVILS KEY TO NEW BUDGET FIGHT

Much has been written about the Conservative Democratic Forum and the importance of its members—called "Boll Weevils"—in deciding issues before the House. These 47 Democrats, most of whom are from the South, are noted for the attention heaped on them by both the President and the Democratic leadership before key House budget and tax-reduction votes earlier this year.

Another equally important House coalition is a band of 24 Northeastern and Midwestern moderate-to-liberal Republicans—the "Gypsy Moths."

Like Conservative Democratic Forum members, "Gypsy Moths," most of whom represent older industrialized urban areas, must walk the fine line between party loyalty and their district's concerns. Rep. Edward Madigan (R-Ill.), appointed by House Minority Leader Robert Michel (R-Ill.) as liaison to this group, says "a dozen (of the 'Gypsy Moths') are among the most vulnerable members of the House. They are respected on those grounds and have been given every consideration." Indeed, most "Gypsy Moths" hold seats in marginal districts and a half-dozen of them are freshmen. This year's redistricting is likely to have a profound effect on reelection of many "Gypsy Moths" in 1982 because more Democratic voters will be brought into their district.

Unlike "Boll Weevils," however, the "Gypsy Moths," so far, have supported almost unanimously their party's leadership and, thus, the President. Only Reps. Charles Dougherty (R-Pa.) and Claudine Schneider (R-R.I.) refused to support unequivocally the Reagan reconciliation proposal; Rep. James Jeffords (R-Vt.) was the lone defector during the tax-cut battle.

As a new round of congressional budget cutting begins, the President and House leaders will be spending long hours courting "Boll Weevils" and "Gypsy Moths."

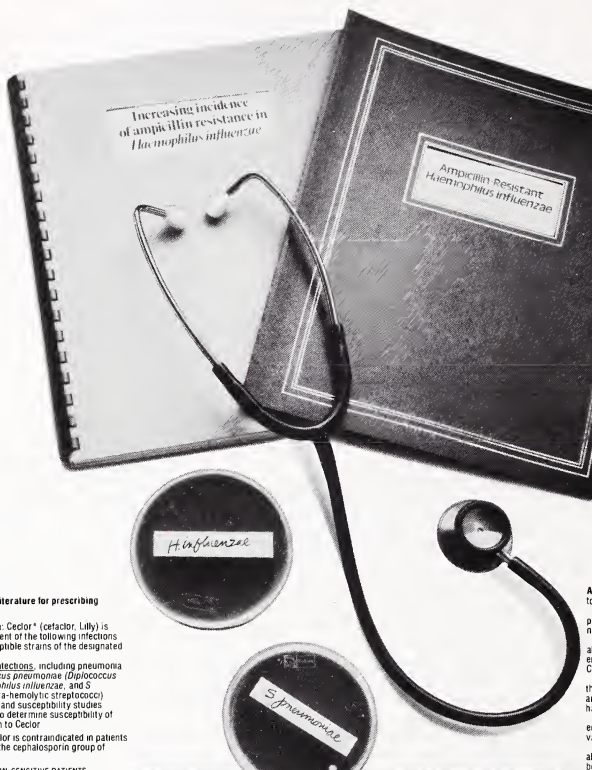
And, as was the case in the Spring, members of those coalitions are likely to be the difference between a victory and a defeat for the Reagan economic-recovery program.

The Gypsy Moths:

Coughlin (Pa.), DeNardis (Conn.), Dougherty (Pa.), Dunn (Mich.), Fenwick (N.J.), Fish (N.Y.), Gilman (N.Y.), Goodling (Pa.), Green (N.Y.), Heckler (Mass.), Hollenbeck (N.J.), Horton (N.Y.), Jeffords (Vt.), McKinney (Conn.), Marks (Pa.), Pursell (Mich.), Regula (Ohio), Roukema (N.J.), Schneider (R.I.), Smith (N.J.), Snowe (Maine), Tauke (Iowa), Weber (Ohio), Williams (Ohio). (*Washington Report*, September 28, 1981)

*Copies of JEMPAC and AMPAC reports are filed with the Federal Election Commission and are available for purchase from Federal Election Commission, Washington, D.C. This item is prepared by the Chairman of JEMPAC Committee, Frank Watson, M.D., and A. Ronald Rouse, JEMPAC Executive Director.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary Consult the package literature for prescribing information

Indications and Usage: Cefad® (cefad, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococcus).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefad.

Contraindication: Cefad is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefad, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefad occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefad may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefad should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefad, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinette® tablets but not with Tes-Tape® (Glucose Chromatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antiferility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established.

The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefad.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococcus), or multiple organisms achieved a satisfactory clinical response with Cefad.⁷

Cefad
Pulvules®, 250 and 500 mg

Adverse Reactions: Adverse effects considered related to cefad therapy are uncommon and are listed below. Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 80).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transient abnormalities in clinical laboratory test results have been reported. Although they are of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[Continued]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefad (cefad) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
3. Antimicrob. Agents Chemother., 12: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Sengeneler and R. Luthy), II, 880. Washington, D.C.: American Society for Microbiology, 1976.
6. Antimicrob. Agents Chemother., 12: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46205.

Eli Lilly Industries, Inc. Carolina, Puerto Rico 00630

100061



Lifeline

THE MEDICAL SOCIETY OF NEW JERSEY
AND MIDDLESEX GENERAL HOSPITAL



LIFE LINE PROGRAM

The Medical Society of New Jersey and Middlesex General Hospital in New Brunswick are recipients of a one-year grant from the Hunterdon Health Foundation to complement the first contracted LIFELINE system in New Jersey. This is the first of a bimonthly series on the progress of the project during its first year of development.

New Jersey's first contracted *Lifeline System* is being established by Middlesex General Hospital and the Medical Society of New Jersey, as corecipients of a \$60,000 grant from the Hunterdon Health Fund, a private charitable foundation affiliated with the College of Medicine and Dentistry of New Jersey.

The *Lifeline System*, located at Middlesex General Hospital in New Brunswick, will provide an emergency response program which will permit subscribers, the chronically ill and the physically impaired, to live independently in their own homes, yet be able to receive emergency assistance at the touch of a button.

Each *Lifeline* subscriber will have an electronic communicator attached to a telephone and a pocket-size remote call button. At the first sign of a medical emergency the person can push a button to send an electronic message, via telephone line, to Middlesex General Hospital's response center.

The hospital response center will be monitored 24 hours a day, seven days a week, by trained personnel. When a *Lifeline* subscriber's code number flashes on a digital screen, an alarm sounds and a printed tape records the emergency signal received.

"LIFELINE IS AN EMERGENCY RESPONSE SYSTEM WHICH ALLOWS THE CHRONICALLY ILL AND PHYSICALLY IMPAIRED TO LIVE INDEPENDENTLY IN THEIR OWN HOMES."

The hospital staff member immediately telephones the subscriber to evaluate the level of assistance needed. If no one answers, immediate action is taken to reach a "responder," a previously identified contact person who lives within five minutes of the subscriber.

A clock-timer automatically will initiate an emergency call should the subscriber be unconscious or unable to press the call button. The clock-timer can be set for 12 or 24 hours and is reset manually. Normal use of the telephone automatically resets the timer. The *Lifeline* system also will function during power failures or if the phone is off the hook.

Middlesex General Hospital's field worker will phone the

subscribers each month to assure the subscribers of continuous monitoring and establish an "in touch" feeling. These monthly calls also will determine the current health status of the subscribers and the functioning of the communication response equipment.

"... ASSURES THE SUBSCRIBER OF CONTINUOUS MONITORING ..."

The mechanical and humanistic features built into the *Lifeline* program reduce the sense of isolation for the subscribers while enhancing a feeling of security for the subscribers.

The Medical Society of New Jersey, as corecipient, is undertaking the task of publicizing, promoting and encouraging the implementation of the *Lifeline* system in other hospitals and communities of New Jersey, via the media, this newsletter, and a spring seminar to be held at Middlesex General Hospital. Details of the seminar will be in a future issue of the *Lifeline* newsletter.

The *Lifeline System, Inc.* was founded by Andrew S. Dibner, Ph.D., an Associate Professor of Psychology at Boston University. The idea of a communications and response system which allows people, who otherwise might be in nursing homes, special care centers, or hospital facilities to live independently first was tested in 1976 in Boston. Since then some 70 *Lifeline* systems have been established throughout the United States.

"... EACH \$1.00 OF LIFELINE SERVICE PRODUCED A NET SAVINGS OF \$7.19 IN TOTAL LONG-TERM CARE ..."

A three-year study of the *Lifeline* program, conducted by the Department of Health, Education and Welfare, concluded that such a program improves the quality of life of the frail elderly, while reducing the long-term care. Specifically the study found:

(a) *LIFELINE LIVING*: *Lifeline* users felt more comfortable about living alone and more confident about continuing to live independently. In addition, *Lifeline* users slept better and moved around their homes with greater ease;

(b) *DAYS OF NURSING HOME CARE*: For each day spent in a nursing home by *Lifeline* users, nonusers required ten days;

(c) *COST/BENEFIT*: For the largest group of *Lifeline* users (severely functionally disabled and not socially isolated) each

\$1.00 of *Lifeline* services produced a net saving of \$7.19 in total long-term care costs due to reduced use of institutional and community services.

Middlesex General Hospital's *Lifeline* program, directed by Barbara L. Goula, R.N., will be available to the entire community serviced by the hospital.

Middlesex General Hospital and the Medical Society of New Jersey, in its commitment to the *Lifeline System*, will be adhering to the following goals:

- (a) To improve emergency medical care to the chronically ill and the physically impaired individual by providing them with ready access to emergency service in case of accident or illness.
- (b) To reduce the sense of isolation for the elderly and the disabled community resident by providing a feeling of security that one can get help quickly in case of need.
- (c) To provide a service that will add to a comprehensive program of support and assistance to the "subscriber" population.

(d) To postpone, shorten or preclude costly institutionalization, and/or to enjoy an independent lifestyle, secure in the knowledge that help is available at the "push of a button" 24 hours a day, seven days a week.

(e) To publicize the program and facilitate its development on a statewide basis.

Future issues of the bimonthly *Lifeline* newsletter will feature: progress reports on the program, family/subscriber responses to the program, incident information, and the results of a private study concerned with the efficacy/reliability and/or affordability of such a system, as well as the role of the private sector in such a venture.

Further information regarding the *Lifeline* project at Middlesex General Hospital may be obtained by contacting A. Ronald Rouse, Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648, (609) 896-1766.

For information regarding the national *Lifeline System* organization contact *Lifeline Systems, Inc.*, 51 Spring Street, Watertown, MA 02172, (617) 923-4141 in MA, (800) 225-3083 out of MA.

Lifeline newsletter may be printed without permission.

**NEW YORK
FERTILITY RESEARCH
FOUNDATION, INC.**

For the Investigation of
Problems of Human Infertility

The Foundation provides a complete diagnostic and consultation service for infertile couples. Investigations are conducted by well-known specialists in conjunction with consultants in the various fields of medicine related to infertility.

The Foundation is supported by an in-house modern laboratory equipped to do most tests required for diagnosis and treatment. Literature on request.

1430 Second Avenue
New York, N.Y. 10021
Phone: 744-5500

**NEED HELP
COLLECTING
PAST DUE
ACCOUNTS?**

**OUR LAW FIRM
CAN SOLVE
YOUR PROBLEMS
AT A COST
FAR BELOW
COLLECTION AGENCY
RATES**

FOR INFORMATION CALL US AT:

201-677-9330

use the Experienced Laboratory



**SOUTH MOUNTAIN
LABORATORIES • INC**

for CONTROL-RESEARCH

SERVICES IN

- PHARMACOLOGY
- ENDOCRINOLOGY
- TOXICOLOGY
- COSMETICS
- BIO-ASSAY
- PLASTIC IMPLANT
- HUMAN SKIN TESTING
- PYROGENS

380 Lackawanna Pl., South Orange, N.J. 07079 (201) 762-0045

1102 Industrial Parkway, Bricktown, N.J. 08723 (201) 458-0031

First Class First Aid

In
your
office

In
their
homes

Recommend

NEOSPORIN® Ointment (POLYMYXIN B-BACITRACIN-NEOMYCIN)

- Broad-spectrum antibacterial
- Handy applicator tip

DESCRIPTION: Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs, in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyoderma (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching. It may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Nonsurgical Evaluation and Management of Malignant Biliary Tract Obstruction*

BARRY I. LOIGMAN, M.D., RICHARD F. MATTERN, M.D.,
RAYMOND F. HEALEY, M.D., THOMAS H. HAYES, R.T., Montclair

A sequence of radiological procedures including ultrasound or computed tomography, percutaneous transhepatic cholangiography, percutaneous biliary bypass, fine-needle aspiration biopsy and transcatheter radiation therapy have been combined in the nonsurgical management of patients with obstructive jaundice secondary to malignant neoplasm. Two illustrative cases are presented.

In patients with clinical and laboratory evidence of obstructive jaundice, ultrasound or computed tomography commonly is performed to confirm dilatation of the biliary tree. Since its introduction, percutaneous transhepatic cholangiography using a thin needle has proved to be a safe, effective method to diagnose the location and etiology of biliary obstruction.¹ Percutaneous transhepatic biliary drainage soon followed as a nonsurgical means of bypassing the obstructing lesion.² We report two cases of pancreatic carcinoma in which we employed transhepatic cholangiography and drainage, fine-needle aspiration biopsy, and iridium intralesional radiotherapy.

MATERIALS AND METHODS

After dilated biliary ducts are demonstrated by ultrasound (US) or computed tomography (CT), percutaneous transhepatic cholangiography (PTHC) is performed using a thin-walled 20 or 22 gauge Chiba needle.³ After local anesthesia, puncture is made in the midaxillary line, and the needle is advanced under fluoroscopic guidance through the hepatic parenchyma toward the midline. The obturator is removed and contrast is injected during gradual withdrawal of the needle until a biliary duct is entered. Additional contrast is injected and the patient is positioned as necessary to image both the point of obstruction (porta hepatis or common duct) and its cause (calculus, tumor, or benign stricture).

Once the intrahepatic ducts have been opacified, an 18

gauge sheathed needle is directed percutaneously through a second puncture site toward an intrahepatic duct selected for its relatively straight course toward the visualized or projected origin of the common bile duct. The needle is removed and the sheath withdrawn until bile can be aspirated, indicating a satisfactory intraluminal position. A guidewire then is introduced through the sheath and may, with manipulation, pass through the region of obstruction into the duodenum. If initial passage of the guidewire is not successful, it often can be accomplished after 24 or 48 hours of external biliary drainage through a catheter exchanged for the sheath proximal to the obstruction. When the guidewire has entered the duodenum, the tract from the skin to intrahepatic ducts may be enlarged with progressively larger dilators, and an 8.3F pigtail catheter (Ring catheter)⁴ is placed to bridge the obstruction. The catheter is positioned with multiple side holes above and below the obstructing lesion, such that bile can flow antegrade into the catheter proximal to the lesion, through the catheter at the point of obstruction, and exit the catheter distal to the obstruction. The system is allowed to drain externally for 48 to 72 hours and subsequently is converted to internal drainage by obturating the external end of the Ring catheter. Daily flushing with normal saline is the only maintenance required, and is

*From the Department of Radiology, Mountinside Hospital, Montclair, New Jersey 07042. Correspondence may be addressed to Dr. Loigman at the hospital.

³Cook, Inc., Bloomington, Indiana

easily performed by the patient or a family member. The Ring catheter is exchanged routinely for a fresh one at three-month intervals, as an outpatient procedure.

With the biliary catheter in place, fluoroscopic localization for needle biopsy readily can be accomplished. The proximal border of the obstructing lesion can be defined by injection of contrast through the external end of the catheter, and its axis identified by the catheter which passes through the lesion. The depth of the lesion can be determined by a horizontal beam lateral radiograph obtained prior to needle puncture, and it also can be evaluated as the needle is advanced by intermittently turning the patient to his side. A 20 or 22 gauge Franseen biopsy needle^a with a four-pronged cutting edge has been used with success at this hospital. It is used in combination with a reusable syringe holder^b to permit necessary suction during manipulation of the needle. Four to six aspirations have been advocated to improve the yield of positive results.⁴

Once biliary decompression has been achieved and the diagnosis of malignancy confirmed by percutaneous aspiration biopsy, iridium¹⁹² seeds can be placed in a linear array along a ribbon and introduced percutaneously through the catheter to provide a highly concentrated dose to the obstructing neoplasm.⁵ Depending upon dosage calculations, iridium remains in place for 24 to 36 hours, and the treatment may be repeated as necessary. During the intralesional radiotherapy, it is advisable to reconvert the system to external biliary drainage, and then to internal drainage after the completion of therapy.

CASE 1

A 52-year-old female was admitted to another hospital with a six-month history of anorexia, weight loss and abdominal pain, as well as the recent onset of jaundice and pruritus. A palpable epigastric mass was noted, and ultrasound showed dilated biliary ducts and suggested a pan-

creatic head mass. CT, for which the patient was referred to Mountainside Hospital, confirmed these findings. The total bilirubin was 8.8 mg/dl, alkaline phosphatase 495 IU and hematocrit 34 percent. After transfer to Mountainside Hospital, PTHC showed irregular tapering and complete obstruction of the intrapancreatic common bile duct (Figure 1). Percutaneous biliary bypass was performed, followed by aspiration biopsy which confirmed adenocarcinoma of the pancreas (Figure 2). Iridium was introduced through the Ring catheter, delivering approximately 3000 rads (at the mucosal surface) in 36 hours (Figure 3). One week later iridium was reintroduced to deliver an additional 3000 rads. External beam irradiation and chemotherapy with 5-fluorouracil were initiated following removal of iridium. By two weeks after the bypass procedure, the bilirubin had decreased to 2.7 mg/dl and jaundice and pruritus largely had resolved. Three months later the patient returned for routine replacement of the Ring catheter which had continued to function well. At this time the abdominal mass was no longer palpable, and contrast injection confirmed excellent biliary decompression (Figure 4). Seven months after the procedure she continues fully ambulatory and has been able to vacation out of state with the Ring catheter in place.

CASE 2

A 70-year-old female was admitted with recent onset of anorexia, jaundice, and pruritus. She had experienced no weight loss or pain. Ultrasound showed dilatation of intra- and extrahepatic biliary ducts and enlargement of the head of the pancreas. PTHC revealed distal common duct obstruction with a configuration suggesting pancreatic neoplasm. A Ring catheter was then introduced, and aspiration biopsy confirmed adenocarcinoma consistent with pancreatic origin (Figure 5). Jaundice cleared promptly. Iridium was in-

^bMedical R & H Products, 9510 Forest Rd., Bethesda, Maryland

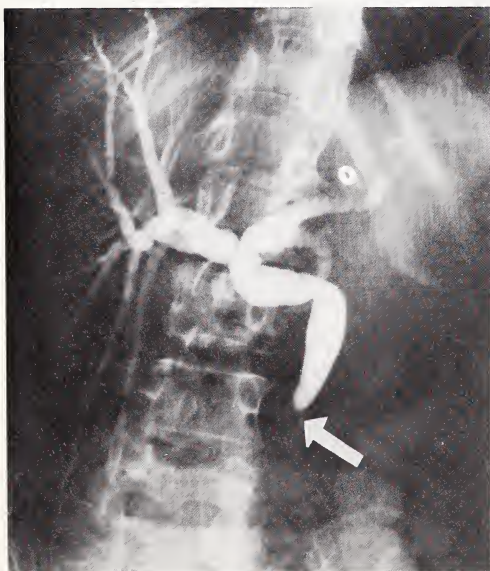


Figure 1—Transhepatic cholangiogram, Case 1. There is abrupt total obstruction of common bile duct (arrow). Contrast in colon is from recent CT scan.

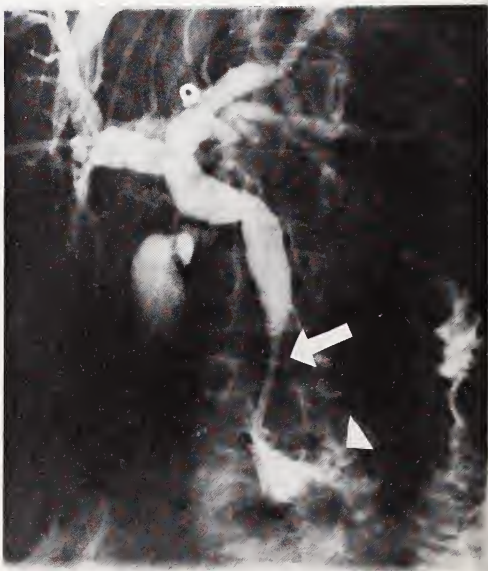


Figure 2—Percutaneous biliary drainage catheter, Case 1. The catheter traverses the level of the obstructing lesion (arrow), and its curved tip lies in the duodenum (arrowhead).



Figure 3—Six iridium seeds lie within the Ring catheter to deliver concentrated intraluminal therapy to the periductal obstructing neoplasm—Case 1.

roduced through the catheter delivering approximately 4000 rads at the mucosal surface. External beam irradiation was then undertaken. The patient has continued to do well at two months' followup.

DISCUSSION

Carcinoma of the head of the pancreas has a dismal prognosis, with mean survival approximating five to seven months.⁶ The vast majority of patients are inoperable at the time of diagnosis and exploratory surgery with or without palliative surgical biliary-enteric bypass has an appreciable operative mortality.³ Percutaneous transhepatic biliary decompression and percutaneous biopsy appear to offer attractive non-surgical alternatives in the management of pancreatic malignancy. If palliative surgery is desired by virtue of the relative youth of the patient and acceptable overall medical condition, or perhaps by the patient's aversion to having the catheter as a permanent reminder of his illness, preoperative percutaneous decompression and resultant de-

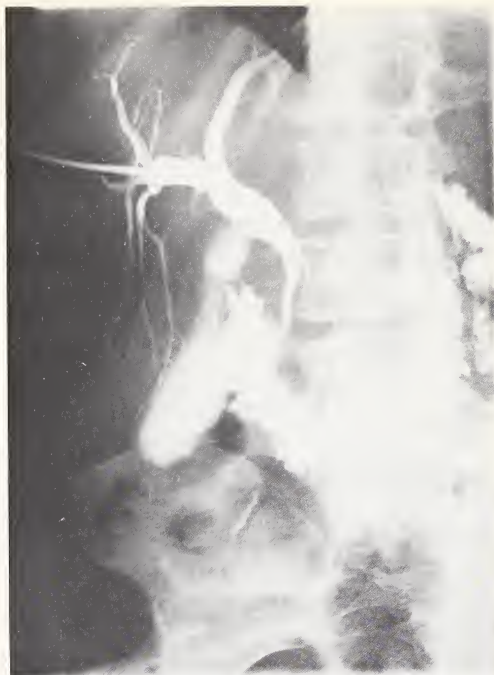


Figure 4—Three-month followup cholangiogram, Case 1. The catheter has been withdrawn and contrast injection confirms patency of the common duct (arrow).

crease in serum bilirubin and improved digestion would be expected to diminish surgical mortality and morbidity.

Although it is an invasive procedure, PTHC is relatively safe, with a complication rate of two to three percent.⁷ One large series of percutaneous drainage procedures had a complication rate of 24 percent but of these only five percent were major complications.³ Most of the minor complications were related to infection following catheter occlusion or dislodgement. Routine systemic antibiotic prophylaxis is recommended for 24 hours pre- and 48 hours postprocedure. Generous sedation should be employed during the procedure as well.

The specimens obtained by the biopsy technique described are usually not large tissue cores, but rather small cell clusters. Expertise in cytological interpretation is therefore essential.

Reports have concluded that external beam irradiation may or may not provide appreciable palliative benefit in carcinoma of the pancreas.⁸ The presence of an indwelling

“Carcinoma of the head of the pancreas has a dismal prognosis, with mean survival approximating five to seven months.”

“Percutaneous transhepatic biliary decompression and percutaneous biopsy appear to offer attractive non-surgical alternatives in the management of pancreatic malignancy.”

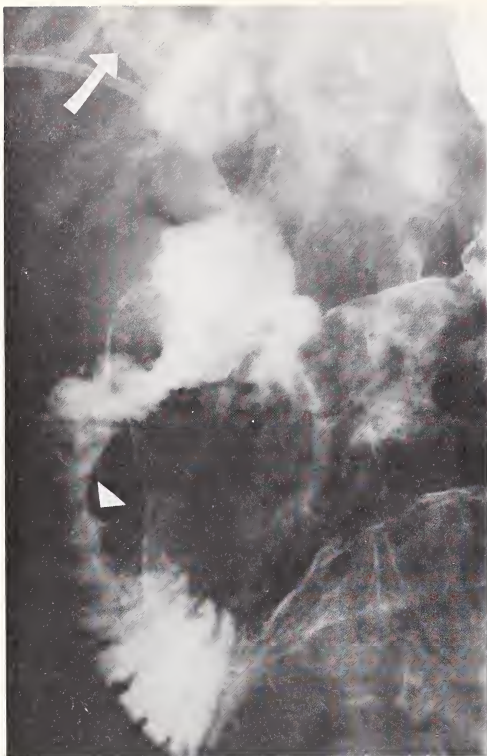


Figure 5—Percutaneous drainage catheter bypasses the obstruction, Case 2. Note dilated biliary ducts (arrow) and mass effect on medial aspect of descending duodenum (arrowhead).

Ring catheter permits the delivery of a highly concentrated dose of irradiation to the obstructing neoplasm. Because of the very localized effect of intralesional iridium, its use has been advocated particularly in cholangiocarcinoma.⁵

SUMMARY

In the patient with clinical and laboratory evidence of biliary tract obstruction, ultrasonography or computed tomography are indicated to confirm dilatation of the biliary tree and search for a cause of the obstruction. When such dilatation is demonstrated, fine needle percutaneous transhepatic cholangiography is indicated to provide anatomical detail, permitting specific localization of the obstructed site and improving accuracy in identifying the nature of the lesion. More recently, percutaneous biliary bypass, in which a catheter is advanced into the dilated intrahepatic biliary radicles, through the region of obstruction, and into the

“Because of the very localized effect of intralesional iridium, its use has been advocated particularly in cholangiocarcinoma.”

duodenum, has been developed. In cases such as carcinoma of the head of the pancreas and metastatic disease to the porta hepatis, in which curative surgery may not be a realistic goal, percutaneous biliary bypass provides an attractive alternative to palliative operative bypass. Guided by the fluoroscopic location of the biliary catheter, fine needle aspiration biopsy can be accomplished. With the diagnosis of malignancy thus confirmed, radiation therapy then may be initiated by advancing a radionuclide such as iridium through the indwelling catheter. This logical sequence of radiological procedures has been combined to evaluate and manage those patients with malignant biliary tract obstruction who are unlikely to benefit from more formidable surgical procedures.

Addendum: Since submission of this article for publication, we have performed percutaneous biliary drainage and intralesional iridium insertion on two additional patients, one with metastatic nodes to the porta hepatis from colon carcinoma and a second with recurrent cholangiocarcinoma and sepsis.

REFERENCES

1. Ferrucci JT Jr, Wittenberg J, Sarno RA, *et al*: Fine needle transhepatic cholangiography: A new approach to obstructive jaundice. *Am J Roentgenol* 127:403-407, 1976.
2. Ring EJ, Oleaga JA, Freiman DB, *et al*: Therapeutic applications of catheter cholangiography. *Radiol* 128:333-338, 1978.
3. Ferrucci JT Jr, Mueller PR, Harbin WP: Percutaneous transhepatic biliary drainage: Technique, results, and applications. *Radiol* 135:1-13, 1980.
4. Staab EV, Jaques PF, Partain C.: Percutaneous biopsies in the management of solid intraabdominal masses of unknown etiology. *Radiol Clin NA* 17:435-459, 1979.
5. Herskovic A, Heaston D, Engler MJ, *et al*: Irradiation of biliary carcinoma. *Radiol* 139: 219-222, 1981.
6. Gudjunsson B, Livstone EM, Spiro HM: Cancer of the pancreas: Diagnostic accuracy and survival statistics. *Cancer* 42:2494-2506, 1978.
7. Gold RP, Casarelle WJ, Stern G, *et al*: Transhepatic cholangiography: The radiological method of choice in suspected obstructive jaundice. *Radiol* 133:39-44, 1979.
8. delRegato JA, Spjut HJ: *Cancer*. St. Louis, Mosby, 1977, pp 582-583.

Foreign Bodies Of The Rectum

HARVEY I. GARBER, M.D., Baltimore; ROBERT J. RUBIN, M.D.,
THEODORE E. EISENSTAT, M.D., Plainfield*

Foreign bodies of the rectum are encountered more frequently in the practice of medicine. Removal without laparotomy presents a major challenge. A new method for dislodgement of foreign bodies of the rectum is presented; the literature on the subject is reviewed.

The need for treatment of foreign bodies of the rectum is increasing.

The surgeon has a major challenge to remove the object without laparotomy. Current methods as well as a new method are described for removal of certain types of foreign bodies.

DISCUSSION

There are several circumstances under which foreign bodies may be introduced into the rectum. These include: self-administered treatment, diagnostic or therapeutic instrumentation, accidental ingestion, criminal assault, and autoeroticism.^{1,2} It is felt by many that the last, autoeroticism, may be the most common cause.² Most foreign bodies are either plastic or latex dildos or plastic vibrators.³ Bananas, cucumbers, carrots and a wide variety of metallic and glass objects have been reported. All of Abcarian's patients were male, mostly in the fourth and fifth decades of life.¹ In another series, only two of 28 patients were women.⁴ Foreign bodies may be classified as either low-lying, those palpable in the ampulla or rectum, or high-lying, those in the proximal portion of the rectosigmoid colon.⁵ The great majority of foreign bodies are removed through the anus; smaller ones may pass spontaneously, while larger ones may require finger extraction or other manipulation.² In removal, local or even general anesthesia and a gentleness are two primary concerns. The avoidance of enemas is recommended, as these

may increase impaction or cause the foreign body to move cephalad.^{2,5}

When a patient comes to the emergency room with a complaint of a foreign body in the rectum, he should have biplane x-rays to determine the location, type and number of foreign bodies. Proctosigmoidoscopy is also a part of the initial evaluation. After appropriate anesthesia and foreign body extraction, proctosigmoidoscopy is repeated to evaluate any injury. A period of observation is recommended should there be any question of perforation.¹ Any patient in whom the foreign body is not palpable needs to be admitted and observed. It is generally found that the foreign body will descend within 12 to 24 hours and become retrievable. Patients with rectal foreign bodies having abdominal pain must be admitted for study and treatment.³ If a deep colonic tear results from either the foreign body or its manipulation, treatment with prophylactic antibiotics and prompt surgical repair, including colostomy, may be necessary.²

Almost all low-lying foreign bodies may be removed by transanal manipulation after local anesthesia.⁵ Those foreign bodies higher up may be much more difficult to remove, and various methods of removal have been described. After

*Dr. Garber presently is a resident in surgery at the University of Maryland Hospital, Baltimore; Drs. Rubin and Eisenstat are members of the staff in the Division of Colon and Rectal Surgery, Muhlenberg Hospital, Plainfield. Correspondence may be addressed to Dr. Eisenstat at 98 James Street, Edison, NJ 08820.

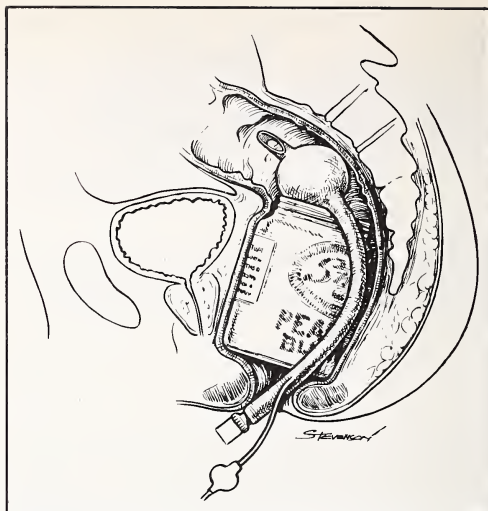
appropriate local anesthesia the anal canal is dilated. This will increase visualization and shorten the anal canal allowing increased ease of manipulation. Biopsy forceps through the anoscope or sigmoidoscope may be used to deliver the foreign body into the rectum. Obstetrical forceps, spoons around the object, tonsil snares and loops, Kocher clamps and uterine tenaculum have been used.⁷ These may be dangerous to use with a glass foreign body, which presents an additional risk of breakage on removal. Wagner, in 1939, described the method of removing a glass jar in which wet plaster of Paris was placed inside the jar. While hardening, a handle was introduced which was used for traction.⁶ In a similar manner, super glue (cyanoacrylate) recently has been reported to affix a spatula or clamp to a nonporous foreign body to afford traction.

Glass removal is complicated further if the opened end of the object is directly cephalad, in that negative pressure is created producing a suction-like effect on the colonic or rectal mucosa. This makes delivery difficult or impossible, and increases the risk of mucosal injury. This suction must be broken to deliver such glass containers. Foley catheters have been used to break the suction by introducing two or more of them around the foreign body and injecting air. Then, with gentle manipulation, delivery may be accomplished.⁵

A NEW METHOD

It may be found, however, that catheters are not rigid enough to pass above the foreign body or to deliver the foreign body. We encountered such a problem recently and employed an endotracheal tube. An endotracheal tube is more rigid and overcomes the problems associated with the Foley catheter. The tube is inserted through the rectum under direct visualization. The curvature of the tube is used to follow the curvature of the sacrum posteriorly. Its distal tip must be positioned above the opened end of the glass container. The inner lumen of the endotracheal tube allows air to enter thus breaking the suction effect (Figure). The cuff of the tube then is inflated and, with gentle traction, aids in dislodging the foreign body from its site and delivering it into the rectum. The relative rigidity of the tube, its curvature, the ability to inflate its cuff and its inner lumen make this a useful instrument in removing foreign bodies.

In general, the above methods and manipulations allow the surgeon to extract most foreign bodies without the need for a laparotomy. Abcarian and Lowe avoided laparotomy in 33 of 36 cases of rectal foreign bodies.^{1,5} Barone *et al.* removed 23 lodged foreign bodies without laparotomy.⁴



Figure—Foreign body and endotracheal tube in place within rectum.

SUMMARY

The removal of foreign bodies from the rectum without laparotomy will continue to challenge surgeons with the increasing incidence of rectal manipulation and auto-eroticism. There have been many case reports of ingenious ways of removing these foreign bodies. The use of the endotracheal tube is presented as another method to remove certain types of foreign bodies in the rectum.

REFERENCES

1. Abcarian H, Lowe R: Colon and rectal trauma. *Surg Cl NA* 58:519, 1978.
2. Lowicki EM: Accidental introduction of foreign body in the rectum. *Ann Surg* 163:395, 1966.
3. Sohn N, Weinstein MA: Office removal of foreign bodies in the rectum. *Surg Gynecol Obstet* 146:209, 1978.
4. Barone JE, Sohn N, Nealon TF Jr: Perforations and foreign bodies of the rectum: Report of 28 cases. *Ann Surg* 184:601, 1976.
5. Eftaiha M, Hambrock E, Abcarian H: Principles of management of colorectal foreign bodies. *Arch Surg* 112:691, 1977.
6. Wagner J: Foreign bodies in the rectum. *Am J Surg* 36:266, 1937.
7. Marino AW Jr, Mancini HW: Anal eroticism. *Surg Cl NA* 58:513, 1978.

The Current Drug Scene

RICHARD J. RUSSO, M.S., Trenton*

A greater availability of heroin and increased use of other psychotropic drugs have placed expanded demands on New Jersey's treatment and rehabilitation services. Federal funds for these services are dwindling. The medical profession should oppose the dismantling of New Jersey's drug treatment network.

If we have learned anything new it is that drug abuse knows no geographical bounds or particular favoritism toward one social group or another. Drug abuse is indeed a global problem which we can ill afford to ignore and which unfortunately will follow us into the next decade. The continued abuse of drugs by Americans is a source of great concern to those of us in public health and medicine who acknowledge the seriousness and extent of the problem.

DRUG ABUSE IN THE UNITED STATES

If we are to reduce drug abuse in the United States, we must change the current social atmosphere which so casually accepts and even glamorizes drug abuse. We are very concerned about the growing social acceptance of drug use in our country; even worse, we have seen a very disturbing trend to glamorize the use of such drugs as marijuana, cocaine and mood elevators and to lull the general public into a false belief that these drugs are harmless so that the use of drugs may become a fashionable pastime. This permissive attitude poses difficulties for medicine and public health and particularly for law enforcement officials.

The adolescent is the most vulnerable individual to confront this growing social acceptance of drug use in our nation. Statistics can give us only an impersonal understanding of the adolescent drug abuse problem, which is further compounded by the distress and confusion aroused by extensive marijuana smoking in many of our schools

today. A recent survey shows that ten percent of high school seniors use marijuana daily. In some communities, the teenagers who have not tried marijuana may be in the minority. If the present adolescent drug abuse trends continue, we soon may experience an alarming number of emotionally, intellectually, and socially handicapped young people as a direct result of their drug use.

OPIUM FROM THE MIDDLE EAST

On the national scene, the explosive growth of opium production in the Middle East, felt throughout western Europe for several years, threatens to provide the United States with an unprecedented heroin epidemic. While this forecast may be viewed by some as overly dramatic, even the most cautious of federal enforcement officials are beginning to sound as if they are preparing for a new "war." The influx of high-quality heroin from Iran, Afghanistan, and Pakistan, more commonly referred to as the "Golden Crescent," is being felt in several major cities in the northeastern part of this country. Current federal reports on the international production of opium continue to be alarming. The "Golden Crescent" produced an estimated 1,500 metric tons of illicit opium in 1979 which would be enough to supply the current

*Read before the Session on Alcohol and Drug Abuse, 215th Annual Meeting of the Medical Society of New Jersey, May 18, 1981, Secaucus. Mr. Russo is Assistant Commissioner, Alcohol, Narcotic and Drug Abuse, New Jersey State Department of Health, Trenton, NJ 08625. Correspondence may be addressed to him there.

heroin market in the United States for about 30 years if it all were smuggled into our country.

This massive worldwide production of opium is appreciated fully only in the light of history. Ten years ago in the 1960s Turkey was the major source of heroin for this country, with an annual production of only about 80 metric tons of opium. It takes about 30 tons of opium to produce one ton of top-quality heroin. The National Institute on Drug Abuse (NIDA) estimates that in 1978, about three-fourths of a ton of heroin supplied our country. By 1979, this had increased to about one and a third tons. We do not have data at this time for 1980, but we expect that there has been a further increase in both supply and demand.

HEROIN ADDICTION AND HEROIN DEATHS

NIDA recently has developed revised estimates on the number of heroin addicts in the United States since 1976. These are:

Table 1

Year	Estimated Number
1976	524,000
1977	495,000
1978	470,000
1979	420,000
1980	480,000

The major part of the increase in 1980 comes from the northeastern corridor, in particular New York City and northern New Jersey. In fact, were it not for our increases which began in 1979, the national picture would have looked much better. There are strong indications that the growing epidemic we have been experiencing for two years in the northeast is spreading to other parts of the country.

Statistics also indicate that heroin-related deaths have been on the decline over the past several years. However, 1980 reports show that the number of deaths in some specific parts of the country, particularly the northeastern section, are on the rise. This has been attributed to an increase in quantity and the purity of heroin coming from Iran, Pakistan, and Afghanistan.

A recent report published by the Addiction Research Foundation of Canada indicates Canadians' growing fears that they are facing an increase in heroin overdose deaths and possibly a new wave of heroin addiction. These fears center on the surprising and dynamic influx of Middle East heroin to western Europe over the past several years which has brought with it record high rates of addiction and overdose deaths. International Health, Education, and Welfare of Canada believes that Canada cannot avoid serious new problems with the increased quantities of Middle East heroin.

Recently, NIDA's Forecasting Branch stated the decline in heroin indicators nationwide continued with the exception that most recent data available indicated an upward trend in the following cities in the northeast: Boston, New York, Newark, Philadelphia, Baltimore, and Washington, D.C. It was further reported that NIDA is aware of a three to four-fold increase in heroin availability from the "Golden Crescent," and a corresponding decrease in heroin coming from Mexico.

At a recent New York City Public Hearing, testimony indicated that in one year drug dependent deaths rose 77 percent in New York City; heroin emergency room episodes increased 46 percent, methadone maintenance treatment

"... information from several sources supports the conclusion that heroin use is continuing to increase in New Jersey ..."

admissions increased 22 percent; and detoxification admissions increased 40 percent; opiate arrests in New York City increased 11 percent; and the purity of the street heroin increased from an average of two to eight percent.

In New Jersey information from several sources supports the conclusion that heroin use is continuing to increase in New Jersey. Admissions to drug treatment in 1980 reached a total of 21,403, a substantial increase over recent years. Total admissions and those for which heroin was the primary drug of abuse are shown below for the years 1978 to 1980.

Table 2

Year	Total Admissions	Heroin Admissions	Heroin as % of Total Admissions
1978	11,112	7,712	69.4
1979	17,278	12,849	74.4
1980	21,403	16,920	79.1

While total admissions increased from 1978 to 1979 by 55 percent, and from 1979 to 1980 by 24 percent, admissions of heroin abusers increased by 67 percent and then by 32 percent. Another way to look at these data is by examining the proportion of all admissions for each year which are for heroin abuse. This climbed from 69 percent to 79 percent. Thus, in terms of our treatment needs, we are responding to increasing numbers of heroin abusers and to a treatment population in which larger proportions of our clients are heroin abusers. In fact, in some of the more serious problem areas in the State, almost 90 percent of all of our admissions are for heroin abuse. Given that the typical heroin abuser entering our system has more serious medical, social, legal, and other problems than do those whose involvement is with many of the so-called "soft" drugs, we are in the difficult situation of needing to respond to ever-increasing numbers of clients with a greater intensity of effort.

DETOXIFICATION AND METHADONE MAINTENANCE

Part of this problem is reflected in the types of admissions for heroin abusers. Typically, more than half of all heroin abusers enter the treatment system through detoxification, either as an end in itself or as a prelude to other, more long-term procedures, such as methadone maintenance or therapeutic communities. The following table compares detoxification to total admissions for heroin abusers:

Table 3

Year	Total Heroin Admissions	Detoxification Admissions	Detox as % of Heroin Admissions
1978	7,712	4,502	58.4
1979	12,849	8,386	65.3
1980	16,920	11,764	69.5

Admissions to detoxification in 1980 represent more than two-thirds of all heroin admissions. Although a great many factors determine whether a client enters detoxification rather than going directly to another treatment modality, we see two major factors as accounting for these increases. First, sharp increases in the availability and purity of street heroin have been directly responsible for increasing the number of abusers who are physiologically addicted and require detoxification. Second, overcrowding at many treatment facilities has reduced sharply our ability to transfer detoxified clients to long-term modalities. Thus, short-term detoxification more frequently becomes the only treatment modality available in these facilities.

This problem is illustrated through admissions *directly* to methadone maintenance:

Table 4

Year	Methadone Maintenance Admissions	Percent of Heroin Admissions
1978	1,072	13.9
1979	1,578	12.4
1980	1,836	10.9

From 1978 to 1980, these admissions increased by 71 percent, but when they are taken as a percent of heroin admissions year by year, they are dropping relative to all heroin admissions. This drop is occurring in spite of the fact that we are seeing increasing numbers of heroin abusers who are appropriate for direct entry into a maintenance process—that is, those who are often referred to as the “hard core” long-term abusers. Too many of these people are being forced to go on our waiting lists, and too many of these eventually slip through the cracks, since the nature of the disease is such that they tend not to wait and be available for entry when we have the space. Very often, these people seek treatment when their addiction becomes so severe that they are engaging in extensive criminal activities to support their habits; some of those who are forced to wait for treatment are arrested in the interim.

Our Department is supporting a new project under the State’s Administrative Office of the Courts to respond to this problem by identifying and diverting substance abusers from the traditional criminal justice system to treatment, but this project can be fully successful only if treatment is, in fact, available.

Using epidemiological techniques, we have been able to estimate that the incidence of new heroin use has increased in 1979 and 1980, exceeding the high levels we found in the early 1970’s. However, when we examine the numbers of users now entering our system who have had no prior treatment, we find that although these numbers are increasing they are remaining roughly equal as a proportion of all entries among heroin users, at about 26 percent to 28 percent. In general, new users do not seek treatment until they have used an average of three or more years, so we anticipate further sharp increases in the numbers of these new users seeking treatment.

OTHER SUBSTANCE AND PRESCRIPTION DRUG ABUSE

Although we have discussed the major heroin problem now facing us, there are a host of other substance abuse problems which seem to crop up with ever-increasing frequency. Marijuana use is so widespread that its social definition is undergoing radical changes. Our treatment

system is seeing increasing numbers of dysfunctional marijuana users, i.e., those who are in definite need of intervention. The illicit use of prescription drugs is also increasing. As an example, there is a very popular combination of drugs being sold on the streets—glutethemide and codeine with Empirin #4. This combination, known to its young users as a “hit,” first came to our attention in a northeastern New Jersey county, but it has spread so that it now is available readily throughout northern and central New Jersey.

Finally, public health and the medical profession in general are faced with a serious and growing dilemma—the inappropriate use of legitimately manufactured and prescribed mood-altering prescription drugs. Our dilemma lies in the fact that very often women who are most appropriate for treatment with these drugs, are the very people with the highest potential of abuse.

Data on incidence of prescription drug abuse among women are difficult to obtain in that it continues to be “in the closet” similar to and often combined with alcoholism. The Drug Abuse Warning Network (DAWN), a national data collection system of hospital emergency room drug-related episodes, provides the best information on drug abuse we have. However, it is incomplete in that it covers only 24 Standard Metropolitan Statistical Areas (SMSA) leaving many hundreds of hospital emergency rooms outside the SMSA reporting system, and therefore, uncounted. Therefore, the DAWN data should be considered as an indication of a much larger problem whose true proportions are as yet unknown.

Table 5

DAWN Total Emergency Room Drug Episodes May 1978 – April 1979				
	Percent	Female	Percent	Male
Total	58.2	69,011	41.6	49,289
White	59.0	43,069	40.9	28,812
Black	52.2	14,507	44.7	11,745

These statistics show that women continue to predominate in the national data on overdose by 16.6 percent over men. The highest percentage, 59.0, is found among white women and the lowest, 40.9, among white men. Those drugs associated with the highest nationwide proportions of female emergency room mentions in DAWN are the following:

Table 6

Generic Name	Female	Male	Trade Name
Diazepam	14,359	7,077	Valium
Aspirin	5,248	1,953	Aspirin
Flurazepam	3,307	1,273	Dalmane
D-Propoxyphene	2,826	1,281	Darvon/Dolene
Amitriptyline	2,335	985	Elavil/Endep
Chlordiazepoxide	2,216	1,056	Librium/Libritabs
Acetaminophen	1,918	680	Tylenol
Clorazepate	1,242	373	Tranxene
Perphenazine/ Amitriptyline	1,169	409	Triavil/Etrafon

With the exception of aspirin, Tylenol® and Darvon® given for relief of pain, the drugs listed are psychotropic: tranquilizers, sedatives, and antidepressants. Dependence on these drugs as a coping mechanism for underlying problems readily can become established, and with increasing tolerance can lead to an emergency room episode reported in the DAWN system.

A recent survey of over 100 women in one New Jersey

"The truth is that we do not know the real dimensions of this problem and it is time for a major research effort to fill this gap."

". . . it is the responsibility of the medical profession to police its own prescribing practices. If this does not happen, someone else will impose prescribing sanctions on the physician."

women's treatment center, found that 53 percent were using one or more prescribed psychoactive drugs when admitted. About half the total named Valium® as the drug of use; 18 percent used minor tranquilizers and 12 percent used anti-depressants. The percentages for sedatives (sleeping pills) and analgesics were slightly lower, roughly 10 and 8 percent respectively. About 24 percent were using two or more psychoactive drugs. Slightly over 16 percent were using prescription drugs whose identity was *not known to the women users*. An equal percentage of the women in the survey (16%) were using alcohol regularly. The average age of the women users was 35 years. Fifty-four percent (54%) of the women using one or more psychoactive drugs were married and 45 percent were separated or divorced. Fifty-five percent (55%) were homemakers while 37 percent were employed outside the home.

Another women's treatment center in New Jersey collected data over a four-year period from a total of 711 women. Three hundred and fifty-five women, or 49.9 percent, were using drugs or medication at the time of admission. Valium® and other tranquilizers were predominant, followed by over-the-counter drugs and alcohol. Over 100 women admitted using cocaine received from a "friend," although they were not regular users. The primary source for the drugs taken by the women was prescriptions from physicians. A small proportion of these (3%) were psychiatrists and the remaining (97%) were general practitioners or internists. In March 1979, this center conducted a random telephone survey of 293 women over 18 and in answer to the question "Do you use drugs or alcohol to cope with stress?" 22 percent of those responding answered affirmatively.

There is no lack of implications in the New Jersey data from women's centers and the national overdose data in DAWN. If we were to project the 22 percent female drug and/or alcohol users identified by the survey above to all of New Jersey, we would arrive at a very, very large number of women who are "potential" serious drug abusers. The truth is that we do not know the real dimensions of this problem

and it is time for a major research effort to fill this gap.

Whatever the real dimensions are, it is the responsibility of the medical profession to police its own prescribing practices. If this does not happen, someone else will impose prescribing sanctions on the physician.

CONCLUSION

All of the above-mentioned indicators reflect a greater availability of heroin and use of other psychotropic drugs which has placed increased demands on the State's treatment and rehabilitation service providers, and at the same time the federal fiscal resources for continuing a concerted treatment and rehabilitation effort is dwindling.

The current Administration's "economic recovery" program appears to be heading toward seriously reducing federal support by 25 percent which could result in New Jersey losing 2.5 million dollars. In addition, a rescission of current formula grant funds would further reduce our funding by 1.2 million. This dramatic reduction in federal funds will result in our decreased capacity to treat substance abusers at a time when we are witnessing increased heroin availability and increased demands for treatment. This can prove to be catastrophic. Needless to say, if Congress does not restore some of these potential fiscal cutbacks, New Jersey is going to face more serious drug abuse problems in our cities and towns in the very near future. We in the New Jersey State Department of Health, the medical community, and all from the private sector who currently are providing substance abuse treatment, rehabilitation, and prevention services, share a very high level of apprehension and frustration over the current federal posture.

I believe, as concerned members of the medical profession and as residents of New Jersey, we should not permit the federal government to "dismantle" our existing treatment network by implementing a system of funding priorities which places fiscal expediency before the impending threat of a new serious drug "epidemic" which can threaten our very nation's future.

STATE OF THE ART

Juvenile Rheumatoid Arthritis

SHELDON D. SOLOMON, M.D., Cherry Hill*

Juvenile rheumatoid arthritis is both a diagnostic and therapeutic challenge for the physician. The different clinical settings as well as the differential diagnosis for each is discussed. Psychosocial, medical and rehabilitative management goals are mentioned.

Juvenile rheumatoid arthritis (JRA) presents a challenge to all practicing physicians. Its mode of presentation is variable, its treatment limited, and its prognosis extremely difficult to predict. This discussion will attempt to give the clinician some broad guidelines.

The mode of onset is variable. Three general categories are identifiable, but each group has subsets (Table 1).

SYSTEMIC ONSET

By far the most difficult to diagnose is the systemic group. Patients usually have extraarticular manifestations including fever, rash, lymphadenopathy, hepatosplenomegaly and serositis. Although arthritis may be present, the dramatic extraarticular features lead one away from the appropriate diagnosis. The pattern of fever is often quite characteristic with wide swings from normal in the morning to 39 or 40 degrees centigrade at night. The child often appears quite toxic with shaking chills and diaphoresis. This leads the physician to consider a septic process as the etiology. Along with the fever spikes, an evanescent rash often appears. It is faint and often is missed if not looked for carefully. It is salmon colored and morbilliform. The lesions may be produced or intensified by scratching (Kobner response). Laboratory tests often are not helpful and may be misleading since a marked leukocytosis (15,000 to 30,000) often is present. The classical stigmata of rheumatoid arthritis, such as

Table 1		
Mode of Onset	Incidence	Subsets
1. Systemic	25%	a) intermittent b) chronic ongoing
2. Monarticular	40%	a) monarticular b) pauciarticular (less than 5 joints)
3. Polyarticular	35%	a) intermittent b) chronic ongoing

positive rheumatoid factor and rheumatoid nodules, are absent in the majority of these cases. It must be stressed that in a child or young adult being evaluated for a fever of unknown origin JRA should be a strong consideration. All too often these patients are put through exhaustive investigation before this diagnosis is considered. Certainly with the toxic appearance, spiking fevers, and leukocytosis, infectious processes and neoplasms have to be excluded (Table 2). The response to salicylates in proper dosages is often dramatic¹ and may be used as a diagnostic test (Figure 1). About 50 percent of this group will have chronic ongoing disease for years while the other half will have intermittent episodes with subsequent attacks mimicking the initial episode.

*Dr. Solomon is Chief, Section on Rheumatology at West Jersey Hospital Systems. He may be addressed at 1860 Green Tree Road, Cherry Hill, NJ 08003.

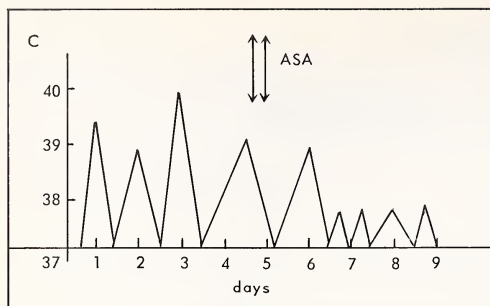


Figure 1—Response of fever to salicylates.

Table 2
Differential Diagnosis of Systemic Onset —
Common Disorders

1. Malignancies
 - a) acute lymphatic leukemia
 - b) lymphomas
 - c) neuroblastoma
2. Infectious Process
 - a) osteomyelitis
 - b) staph arthritis
 - c) viral infections
 1. rubella
 2. infectious hepatitis
 3. infectious mononucleosis
3. Inflammatory Conditions
 - a) Rheumatic Fever
 - b) Henoch Schönlein purpura
 - c) other connective tissue diseases
4. Miscellaneous Disorders
 - a) Sickle Cell anemia
 - b) familial Mediterranean fever
 - c) inflammatory bowel disease

Table 3
Synovialysis — Monarticular Arthritis

	<u>Trauma</u>	<u>Rheumatoid</u>	<u>Infectious</u>
Gross	clear or bloody	cloudy	opaque
WBC's	< 3000	10,000 — 20,000	> 100,000
Diff	< 25% polys	50% to 75% polys	> 75% polys
Culture	negative	negative	positive

MONARTICULAR ONSET

Here, the presentation is much less dramatic. Often the mother notices only a painless limp. The most commonly involved joint is the knee. There are few systemic manifestations, however the most significant extraarticular manifestation is iridocyclitis and its sequela. This complication may occur in 20 to 40 percent of these patients and is particularly dangerous because it is often asymptomatic for weeks or months until visual impairment occurs. Infant girls with positive antinuclear antibodies have an extremely high risk for this complication. The paucity of laboratory abnormalities parallels the lack of systemic manifestations. A mild anemia and mildly elevated erythrocyte sedimentation rate may be all that is present. With monarticular involvement the single most important study is synovialysis.² Arthrocentesis, particularly of the knee, is an easy outpatient procedure. I have performed it in children as young as five years without difficulty. In a younger, uncooperative child the risk of a general anesthetic will have to be weighed against the information that can be obtained (Table 3).

The fluid should be collected in an anticoagulated tube preferably with heparin. Gross examination can be done by the bedside while the routine procedure, i.e., white blood cell count, differential, culture and sensitivity, can be performed at almost any laboratory. All too often physicians are reluctant to aspirate a joint, leading to considerable waste of time, money, and patient discomfort. I have seen unnecessary casts applied to a number of children for "sprains" with the correct diagnosis becoming all too obvious once cloudy synovial fluid was obtained. If there is a high index of suspicion for tuberculosis (i.e., recent tuberculin converter), a synovial biopsy should be considered even if the smear and culture of the synovial fluid are negative. As in the systemic onset the differential diagnosis covers many areas as diverse

as splinter-induced synovitis³ to gonococcal arthritis (Table 4). The clinical course of monarticular disease is one of low-grade involvement of usually less than four joints with a few patients going into remission and a few going on to polyarticular disease.

Another disease producing a mono or pauciarticular arthritis is Lyme arthritis. This is a relatively "new" disease first having been described in the past four years.⁴ Its telltale signs—tick bite and the characteristic skin rash, erythema chronicum migrans—are often asymptomatic and only the arthritis comes to the forefront. Hence, a misdiagnosis of juvenile rheumatoid arthritis may be made. The diagnosis no longer is limited to the Connecticut River valley and has been reported in many counties of New Jersey. Europeans have treated this skin rash with penicillin for many years and it has been suggested recently that the arthritis is abated with concomitant antibiotics as well as high doses of salicylates.

POLYARTICULAR ONSET

This presentation occurs in greater than one-third of affected children. It is likened to the adult variety with onset of greater than four joints in a symmetrical fashion associated with fatigue and morning stiffness. A bimodal age onset distribution is noted first during the second year of life and then between eight and ten years. The polyarthritis may be accompanied by some of the extraarticular manifestations such as rash, adenopathy and pericarditis but to a lesser extent than in the systemic form. One characteristic finding not shared with the adult form is radiographic abnormalities of the cervical spine with fusion of the apophyseal joints between C2 and C3. In the differential diagnosis of polyarticular disease, rheumatic fever is most often difficult to distinguish. An ASO titer may be elevated in 30 to 50 percent of juvenile rheumatoid arthritis patients. The dis-

Table 4
Monarticular Arthritis

1. Trauma
 - a) non-penetrating
 - b) penetrating
 1. plant thorn
 2. splinter
2. Inflammatory
 - a) inflammatory bowel disease
 - b) ankylosing spondylitis
 - c) psoriatic arthritis
3. Tumors
 - a) bone contiguous to joint — osteoid osteoma
 - b) metastatic to bone
4. Infectious
 - a) pyogenic infections — staph, strep
 - b) tuberculosis
 - c) gonococcal

Table 5
Management

1. Child and parental guidance and education
2. Medical program
3. Exercise program
4. Surgery

“...distinguishing features which suggest juvenile rheumatoid arthritis include a non-migratory symmetrical polyarthritis, onset under five years, cervical spine involvement and a marked leucocytosis.”

tinguishing features which suggest juvenile rheumatoid arthritis include a nonmigratory symmetrical polyarthritis, onset under five years, cervical spine involvement and a marked leucocytosis. Serum sickness often mimicks JRA because of the fever, rash and polyarthritis. Other connective tissue diseases such as systemic lupus erythematosus (SLE) and periarteritis nodosa often have to be considered. The leading causes of a viral arthritis which has a polyarticular presentation include rubella or rubella vaccination and infectious hepatitis. Mucocutaneous lymph node syndrome may present as polyarthritis with accompanying lymphadenopathy but a distinguishing feature is erythema of the palms and soles which often desquamates.⁵ Another frequent cause of polyarticular joint pain is the hypermobility syndrome, a benign problem which requires little treatment.⁶ Here recognition is critical so that the patient and family can be reassured.

MANAGEMENT

After the appropriate diagnosis is made management must be directed toward the whole patient (Table 5). Parents must be educated and strong direction given to prevent overprotection. Every attempt must be made to raise the child as normally as possible. Patients with JRA should not think of themselves as invalids, but should attempt to attend regular school and be involved in as many regular activities as possible. This often requires a great deal of communication between the physician, teacher, school nurse, and principal.

The goals of medical therapy include reduction of pain, maintenance of function, and prevention of deformities. The treatment of choice, as in adults, is salicylates. It must be stressed that their usage is primarily for their anti-inflammatory effect so that amounts attaining the proper therapeutic levels must be used. In children weighing less than 25 kilograms (kg) the amount of aspirin needed is 100 mg/kg. In children weighing more than this, 10 to 12 tablets per day usually is adequate to obtain salicylate levels in the therapeutic range of 20 to 30 mg/dl. Dosage should be divided so

that the aspirin is taken with three or four meals daily. Once again the teacher or school nurse is critical in making sure the child adheres to the recommended dosage. Careful monitoring of the clinical course and salicylate level is required. Most side effects, such as gastrointestinal upset and salicylism, can be prevented by adhering to the aforementioned precautions. Although aspirin can affect platelet function, clinical bleeding is rarely, if ever, a problem. This must be conveyed to the parents so that the prescribed dose will be adhered to. Recent attention has been directed to the "hepatotoxicity" of aspirin in these children.⁷ It must be stressed that this is rare and usually just a laboratory abnormality, i.e., elevation of the SGOT. Even continued usage usually does not lead to progressive liver disease in this small subset of patients. Outside of the United States many non-steroidal anti-inflammatory agents (NSAIA) are used in the treatment of JRA, although at the present time (May, 1981) only tolmetin sodium has FDA approval in this country.⁸ As in adult rheumatoid arthritis, the NSAIAs are generally inferior to aspirin although in selected patients one of these may be superior.

Corticosteroids should play only a limited role. Intra-articular injections, if used sparingly, can be extremely beneficial particularly when only one joint is involved. Systemic steroids should be reserved for either extra-articular involvement or, in small dosages, in the most severe cases of polyarticular disease. The use of disease modifying anti-rheumatic drugs, such as gold salts, are outside of the scope of this paper. Consultation with a rheumatologist is a must before embarking on these treatments.

Exercise is critical in the treatment program to prevent deformity and maintain function. Swimming and bike riding are excellent substitutes for contact sports such as basketball and football. A formal exercise program should be taught to both the child and the parents with stress placed on the necessity of performing the program daily. Generally this program includes instruction in isometric and range-of-motion exercises.

Surgery has its greatest potential in the older child with serious hip or knee disability. Joint prostheses are being employed with great success. Referral to a center where a team of specialists can consult would be mandatory before deciding on any orthopedic procedure.

SUMMARY

Juvenile rheumatoid arthritis can be quite a challenge to the attending physician. Its onset usually falls into one of three categories including either monoarticular, systemic, or polyarticular. Each subset has a long differential diagnosis and usually juvenile rheumatoid arthritis is determined by excluding these other possibilities. Synovial analysis can be one

of the few tests which is more specific since the presence of a cloudy Group II fluid suggests an inflammatory process as juvenile rheumatoid arthritis rather than a mechanical or traumatic etiology or septic process. Other studies such as the rheumatoid factor are usually not helpful since the sensitivity is 10 to 20 percent. In this era of modern technology juvenile rheumatoid arthritis is one of the few remaining diseases that is diagnosed mainly on clinical data alone.

Treatment can be as difficult as the diagnosis. Aspirin is still the drug of choice but scrupulous attention must be paid to its administration. Appropriate dosage requires periodic checks on blood salicylate levels and parents must be warned about potential insidious symptoms of salicylism. We strive for blood levels between 20 to 30 mg/dl. Total management requires enlisting the aid of the child's family, teacher, school nurse, and principal with the major thrust being an attempt to keep the child feeling as independent and normal as possible. Occasional steroid injections, gold therapy, and even joint replacement are used in more severe cases. Careful ophthalmologic followup is essential to prevent ocular complications.

The effort placed in coordinating this comprehensive management program will be rewarded by seeing the child prevented from developing deformities, limitation of motion, and by having less pain.

REFERENCES

1. Ansell BM: The management of juvenile chronic polyarthritis. *Practitioner* 208:91-100, 1972.
2. Calabro JJ, Parrino GR, Marchesano JM: Monarticular onset juvenile rheumatoid arthritis. *Bull Rheum Dis* 21:613-616, 1970.
3. Solomon SD: Splinter-induced synovitis. *Arthr Rheum* 21:2, 1978.
4. Steere AC, Malawista SE, Snudman DR, Shope RE, Andiman WA, Ros MR, Steele FM: Lyme arthritis. *Arthr Rheum* 20:7-17, 1977.
5. Kawasaki T, Kowsaki F, Okawa S, Kiegematse I, Yanagawa H: A new infantile acute febrile mucocutaneous lymph node syndrome (MLNS) prevailing in Japan. *Pediatr* 54:271-276, 1974.
6. Jessee EF, Owen DS, Sagar KB: The benign hypermobile joint syndrome. *Arthr Rheum* 23:1053-1056, 1980.
7. Athreya BH, Gorske AL, Myers AR: Aspirin-induced abnormalities of liver function. *Am J Dis Child* 126:638-641, 1973.
8. Levinson JE, Baum E, Fink C, Hanson V, Schaller J: Comparison of tolmetin sodium and aspirin in the treatment of juvenile rheumatoid arthritis. *J Pediatr* 9:799-804, 1977.

Help for Impaired Physicians

We need YOU to tell us about an impaired colleague!

Experience clearly shows that victims of chemical abuse and most psychiatric impairments are not capable of perceiving their behavior realistically. Therefore, they are incapable of reaching out *by themselves* for the help needed to avoid irreversible damage to themselves and others, and to take the first step toward rehabilitation.

The Impaired Physician Committee of MSNJ is a group of physicians, many of whom have recovered from substance abuse and addiction, who approach impaired physicians with advocacy and experience.

We know that you, personally, do not know what to do with these colleagues. We do! But we have to know who they are. The earlier the problem is recognized and attacked, the easier it is to solve.

It is normal human behavior to ignore problems that appear insoluble. Unfortunately, the psychopathy of substance abuse and addiction always gets worse while it is ignored.

TRUST US! We can help in the majority of cases. Your anonymity is guaranteed. Call (609) 896-1884—only specially trained personnel will handle your call.

Help us to help our impaired colleagues.

An Unusual Cardiovascular Foreign Body: Discussion of Etiology and Nonoperative Retrieval*

JOHN V. CHOLANKERIL, M.D., SIDNEY KETTER, M.D.,
OSCAR VERZOSA, M.D., FRANK GURAL, R.T., Elizabeth

A mentally retarded, institutionalized teenager developed multiple lung abscesses due to a foreign body, a piece of plastic, in the right atrium. The possible modes of entry and migration in the vascular system are discussed. The foreign body was retrieved by a biliary stone removal basket. The patient expired from massive hemoptysis on the eighth hospital day.

There are numerous reports in the literature concerning foreign bodies in the cardiovascular system and their migration.^{1,6-8,12-15} The most common are catheters used for intravenous therapy and central venous pressure monitoring.^{2,10,11} The second most common cause is trauma due to gunshot wound or peripheral trauma.^{1,6,8,12-15} Cardiovascular foreign bodies secondary to perforation of the gastrointestinal tract and genitourinary tract also have been described.

These foreign bodies can be retrieved nonoperatively. We will describe a patient with an unusual cardiovascular foreign body and its removal and complications.

CASE HISTORY

A 14-year-old mentally retarded male was transferred to St. Elizabeth Hospital on May 14, 1976, from Woodbridge State School for high fever unresponsive to ampicillin therapy. Three repeated blood cultures grew Alpha hemolytic streptococci. No valvular vegetations were demonstrated on "M" mode echocardiography. Chest x-ray and tomograms (Figure 1—A, B, C) showed multiple pulmonary nodules with necrotic centers probably representing lung abscesses. A tubular foreign body in the region of the right heart extending to the region of the inferior vena cava was noted. X-ray of the esophagus showed this foreign body to be anterior to that organ (Figure 2). An inferior vena cavagram showed

this foreign body to be in the right atrium and inferior vena cava (Figure 3—A, B).

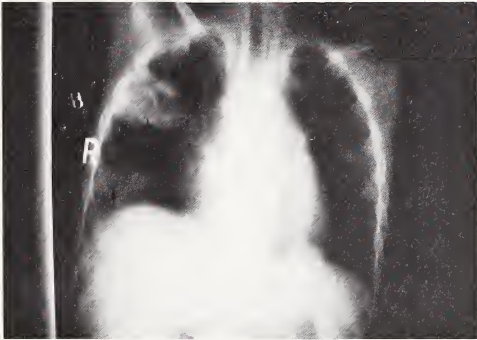
A biliary retrieval set was used in the x-ray department in an attempt to remove the foreign body. A catheter was introduced into the right atrium through the femoral vein. A helical stone basket was inserted into the heart through the catheter. The wire basket was opened anterior to the foreign body. As the basket gently was rotated the foreign body fell into the basket and by pulling the basket handle, the catheter was advanced over the basket and the basket was closed. At this point the patient experienced ventricular tachycardia which ceased when the foreign body and the retrieval catheter were withdrawn from the heart into the inferior vena cava. The foreign body was brought down to the right inguinal region (Figure 4—A) where it was removed by phlebectomy. This foreign body was a solid piece of plastic with a sharp end. It measured 11.4 cm. in length and 3 mm. in diameter (Figure 4—B). The patient died on the eighth hospital day from severe hemoptysis.

Autopsy showed multiple pulmonary abscesses. The superior branch of the left lower bronchus showed a 0.5 cm. side-

*From the Department of Radiology, St. Elizabeth Hospital, Elizabeth. Dr. Cholankeril is Associate Director of Radiology, Dr. Ketter is Chief of that department, Dr. Vergosa is attending in the Department of Internal Medicine and Dr. Gural is a radiology technician. Correspondence may be addressed to Dr. Cholankeril at the hospital, 225 Williamson St., Elizabeth 07207.



A



B



C

Figure 1—A—Chest x-ray: Multiple nodular densities are seen (arrows). B—Tomogram of the chest: Nodular densities showing necrotic center (arrows). C—Over penetrated view: A tubular foreign body is seen (arrow) in the region of the right heart and inferior vena cava.

to-side perforation of a pulmonary artery branch secondary to the adjacent lung abscess, which caused the fatal hemorrhage. The exact site of entry of the foreign body could not be determined.

DISCUSSION

This severely mentally retarded, institutionalized male presented with high fever and multiple lung abscesses (Figure 1—A, B, C). The source of the lung abscesses was a foreign body about 11.5 cm. long and 3 mm. in width in the right atrium and inferior vena cava.

The most common cause of migratory cardiovascular foreign bodies is iatrogenically introduced catheter fragments from intravenous therapy and central venous pressure monitoring.^{2,10,11} Trauma is the next common cause. There are numerous reports in the literature of bullets entering one part of the body, migrating to various blood vessels and heart chambers which are distant from the original portal of

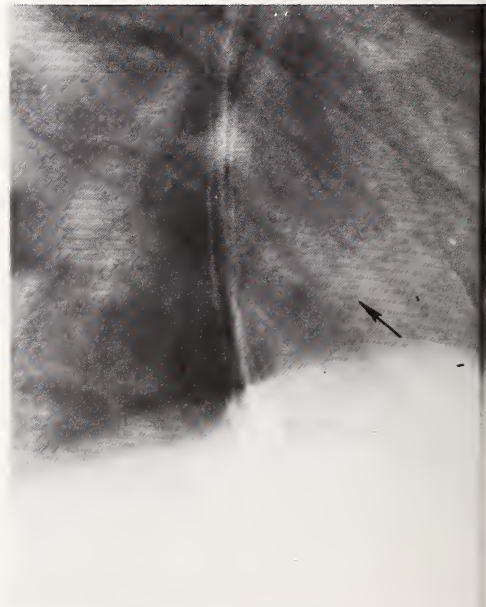


Figure 2—Esophagogram: Tubular foreign body is seen anterior to the esophagus. (arrow)

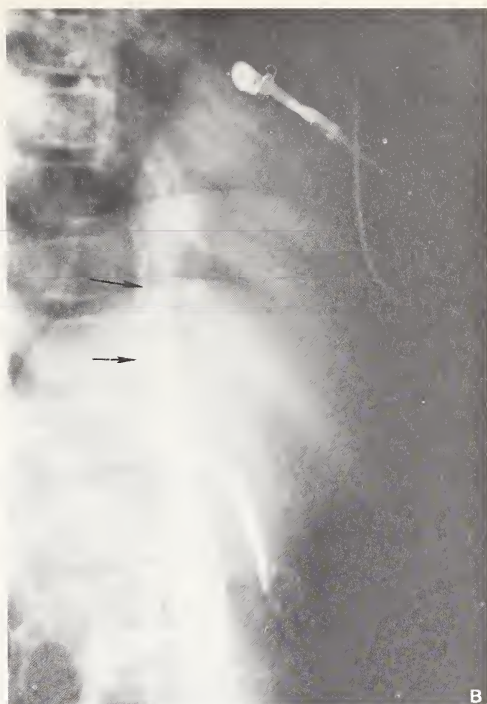
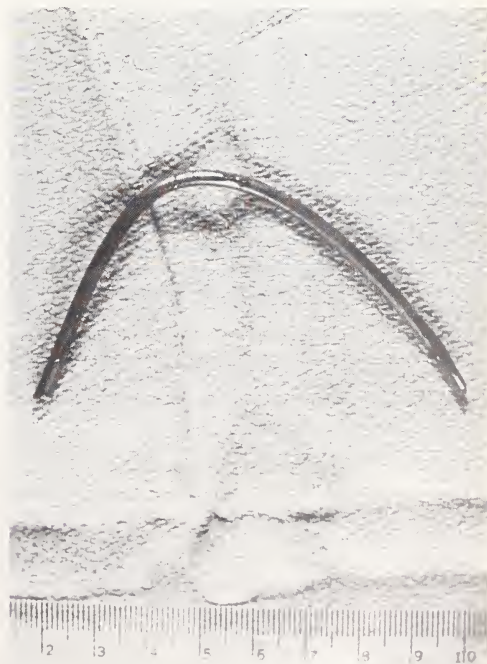


Figure 3—Inferior vena cavogram: A. frontal B. lateral—Both show the foreign body to be in the right atrium and in the inferior vena cava. (arrows)



Figure 4—A—Foreign body (arrow head) and the wire basket (arrow) in the right femoral vein.
B—Foreign body: 11.5 cm. long and 3 mm. in width with no inner lumen and a sharp end.



entry.^{1,6,8,12-15} Foreign bodies also enter the soft tissue and find their way into the peripheral veins of the upper extremity, lower extremity or the neck.¹ Foreign bodies can enter the hepatic veins and into the inferior vena cava through the liver by superficial injuries¹ or through the lung into the pulmonary circulation, pericardium or right and left heart circulation.

Another portal of entry to the vascular system is the alimentary tract. Perforation of the pyriform fossa and

migration into the jugular veins has been reported.¹ Perforation of the third portion of the esophagus and migration of the foreign body to the vascular system or pericardium does occur.¹ Another common entry site is the third portion of the duodenum with entry of the foreign body into the inferior vena cava where the third portion of duodenum is overlying the vena cava. Perforation of the other portions of bowel are rare although they also can occur.¹

Blaha reported a case of a foreign body in the inferior vena cava which a young woman introduced into the genital canal for abortion.¹ Thus perforation of the genitourinary tract or rectum and migration of the foreign body to the hypogastric vessels and to the other areas of the vascular system is possible. Objects such as radium needles and metallic pins placed in the body for treatment have been reported to have migrated to the vascular system.^{1,9}

In our case, the exact site of entry was unknown. It may have entered through gastrointestinal or genitourinary tracts or it may have been introduced through accidental or self-inflicted peripheral trauma. Since the sharp end of the foreign body is pointed upwards, the site of entry probably was below the heart. Autopsy did not show any perforation of the organs or any obvious site of entry. In previous reports, perforations of the gastrointestinal or genitourinary tracts rarely were found since they heal quickly after perforation by a thin pointed object.¹

Thomas *et al.* first retrieved a foreign body from the right atrium by bronchoscopic forceps introduced through the jugular vein in 1964.³ Since then, various methods have been described in the literature. They are as follows:

1. Snare technique using a long spring guide wire acutely bent at its middle and the loop threaded through a large vascular catheter.^{2,10,11}
2. Redundant loop technique which uses a coaxial catheter system.⁴
3. Endoscopic forceps.^{2,3,11}
4. High torqued catheters with a hook at the end.²
5. Helical wire baskets: This system utilizes a helical steel wire basket introduced through a vascular catheter. The helical basket opens when it is pushed out of a catheter and closes when it is pulled into the catheter (Figure 5). Various modifications are available like the Bean-Smith—Mohorner basket and the Burhenne's basket which are used to remove common bile duct stones, the Dormier basket used to remove ureteral stones and the Dotter cardiovascular foreign body retrieval set.^{2,5,11} These instruments have a sharp pointed end. A recent modification of this system is the addition of a straight filiform tip to obviate the potential hazard of perforation.²

In our patient we used the biliary stone removal basket to retrieve the foreign body. This system is more flexible than the Dotter retrieval set¹¹ and can be used also to retrieve a foreign body from the pulmonary artery.

The endoscopic forceps are rigid and short and thus limited in usefulness.^{2,11} The snare techniques and the catheter techniques also are limited in their applications.^{2,11}

Techniques for foreign body retrieval from the heart and great vessels are not without hazards and arrhythmias can occur as in our patient.¹⁰ It also would be possible to damage structures within the heart and great vessels or perforate them while handling the retrieval system.

SUMMARY

A 14-year-old mentally retarded teenager presented with high fever. The chest x-ray showed a tubular foreign body in

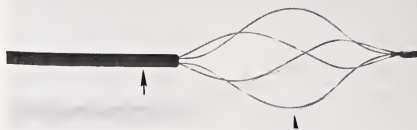


Figure 5—Biliary stone retrieval system: Wire basket (arrow head) Catheter (arrow).

the region of the right heart and inferior vena cava. Multiple nodular densities were found in the lung field due to lung abscesses thought to be originating from the septic foreign body in the vascular system. This foreign body was presumed to have entered the vascular system by peripheral trauma or by piercing the gastrointestinal or genitourinary tract. It was retrieved by a biliary stone removal basket. The patient expired on the eighth hospital day due to severe hemoptysis. The autopsy showed multiple lung abscesses. A branch of the left lower lobe bronchus showed a perforation to a pulmonary artery branch adjacent to an abscess which caused the fatal hemorrhage.

REFERENCES

1. Barrett NR: Foreign bodies in the cardiovascular system. *Br J Surg* 37:416-444, 1950.
2. Bloomfield DA: The non-surgical retrieval of intracardiac foreign bodies. *Catheter Cardiovasc Diag* 4:1-14, 1978.
3. Thomas J, Sinclair-Smith BC, Bloomfield DA, Devachi A: Non-surgical retrieval of a broken segment of steel spring from the right atrium and inferior vena cava. *Circulation* 30:106-108, 1964.
4. Dotter CT, Rosch J, Bilabo MK: Transluminal extraction of catheters and guide fragments from the heart and great vessels: 29 collected cases. *Am J Roentg* 111:467, 1971.
5. Lassers BW, Pickering D: Removal of iatrogenic foreign body from aorta by means of a ureteral stone catheter. *Am Heart J* 73:375, 1967.
6. Moncada R, Matuga T, Unger E, Freeark R, Pizarro A: Migratory traumatic cardiovascular foreign bodies. *Circulation* 57: 186-189, 1978.
7. Jui-Chung Yu, Kwok-Kei Cheng: Migration of broken sewing needle from arm to heart. *Chest* 67: 626, 1975.
8. McCormack PM, Knapper WH: Unusual foreign body pathway to the heart. *JAMA* 238: 2016, 1977.
9. McCaughan JS, Miller PR: Migration of Steinmann pin from shoulder to lung. *JAMA* 223: 1917, 1969.
10. West RO, Charette EJP, Parker JO: Technique for removal of detached polyethylene catheters from intracardiac chambers and great vessels. *Can Med J* 117: 1310-1315, 1977.
11. Alridge HE, Lee J: Transcatheter removal of catheter fragments from the great vessels and heart. *Can Med J* 117: 1300-1304, 1977.
12. Saltzstein EC, Freeark RJ: Bullet embolism to the right axillary artery following gunshot wound of the heart. *Ann Surg* 72: 88-89, 1946.
13. Bartlett H, Anderson CB, Steinhoff NG: Bullet embolism to the heart. *J Trauma* 13: 476-479, 1973.
14. Trimble C: Arterial bullet embolism following thoracic gunshot wounds. *Ann Surg* 168: 911-916, 1968.

Primary Mediastinal Lipoma

ROBERT F. SARAMA, M.D., W.A. DIGIACOMO, M.D.,
B.H. SAFIRSTEIN, M.D., Newark*

This report documents the rare occurrence of a primary mediastinal lipoma. A preoperative diagnosis was made by percutaneous lung biopsy and the patient was cured by surgical resection.

A 60-year-old female came to St. Michael's Medical Center because of chest pain and shortness of breath of one-month duration. She was a nonsmoker who denied weight loss, fever, hemoptysis, night sweats, or anorexia. She had no previous cardiac history, leg swelling, or travel history. Physical examination revealed a blood pressure of 140/70 mmHg, resting pulse of 96 per minute, and oral temperature of 98.6 F. There was no neck vein distention or cervical adenopathy. Percussion of the thorax demonstrated dullness over the right lower lobe, associated with diminished breath sounds. Tactile fremitus was diminished.

Chest x-ray revealed a homogeneous density occupying two-thirds of the right thorax and a similar homogeneous density occupying one-third of the left thorax (Figure 1). The radiograph was compatible with bilateral pleural effusion or pleural tumor. Needle aspirations on two occasions failed to show free fluid.

Tomography of the chest showed two mass lesions, one obliterating the right middle and lower lobes, and the other an eight cm lesion occupying the left lower lobe. Computerized axial tomography of the chest confirmed the presence of bilateral mass lesions whose density was compatible with lipoma.

Bronchoscopy showed complete occlusion of the middle and right lower lobe bronchi. Bronchial brush biopsies and washing were normal. X-rays of the bowel, kidney, and

stomach were normal. A "true cut" percutaneous lung biopsy of the right lower lobe density under fluoroscopy revealed normal adipose tissue. At thoracotomy a seven-pound, yellow, encapsulated mass compressing the right lung continuous to the left lung through the mediastinum was removed. Postoperative chest radiographs showed reexpansion of the right and left lung (Figure 2). A preoperative vital capacity of 0.6 liters increased postoperative to 2.4 liters. All symptoms of dyspnea and pain abated upon discharge, ten days after surgery.

DISCUSSION

The purpose of this communication is to document the occurrence of an intrathoracic lipoma, a rare benign tumor. This report also emphasizes the difficulty in diagnosing such a tumor preoperatively, but underscores its importance because of the curative results that can be accomplished surgically.

Benign intrathoracic tumors are rare; lipoma is the least common.¹ Jensen and Petterson reviewed 3502 pulmonary tumors and found only three instances of lipoma.² In all three cases the lipomas were unilateral. Multiple in-

*This study is from the St. Michael's Medical Center, Newark, where Dr. Sarama is a fellow in pulmonary medicine, Dr. DiGiacomo is attending and Dr. Safirstein is Director of Pulmonary Medicine. Correspondence may be directed to Dr. Sarama at the Medical Center, 268 High Street, Newark, NJ 07102.

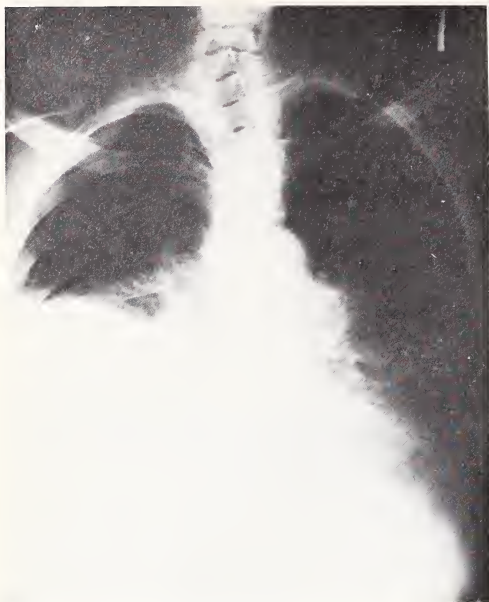


Figure 1—Preoperative PA film of patient.

trathoracic lipomas have been reported in only two cases in the English literature.³ Our patient had bilateral masses on the chest x-ray which initially made us suspect bilateral pleural effusions. Symptoms depend on the size of such tumors and develop as a result of compression of adjacent structures. Our patient suffered with dyspnea and had a resting vital capacity of 600 cc. The patient had such diminished pulmonary functions that we initially dismissed any diagnostic surgical procedure as being hazardous.

Lipomas occur within the thorax in a variety of ways. Endobronchial lipomas arise from the submucosal fat of the tracheobronchial tree and may present with airway obstruction. Parenchymal lipomas often present as solitary peripheral nodules. Pleural lipomas grow into the pleural space. The mediastinum is the most common site of intrathoracic lipomas, which constitute approximately two percent of all primary mediastinal neoplasms.⁴

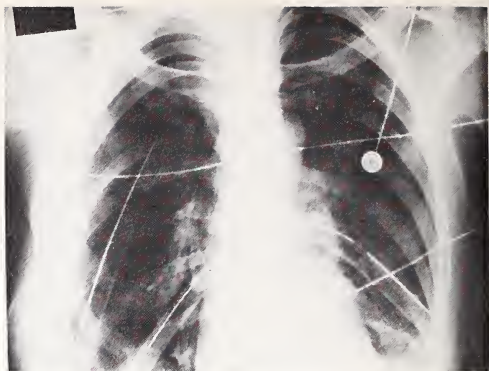


Figure 2—Postoperative AP film of patient.

Our patient had such a tumor and illustrates how such tumors can grow to enormous size before producing symptoms. Leopold reported one such lipoma weighing seventeen and a half pounds.⁵

SUMMARY

The presentation illustrates the case of a sixty-year-old female presenting with dyspnea. The diagnostic techniques chest x-ray, bronchoscopy, tomography, needle aspiration, computerized axial tomography, and percutaneous true-cut needle biopsy paralleled our diagnostic considerations. The diagnosis of benign lipoma was made by the final technique.

The presentations of benign lipomas, their incidence, and the therapeutic approach to such tumors are the basis of the discussion of this paper.

REFERENCES

1. Politis JP, Funashaski A, Gehlsen JA: Intrathoracic lipomas. *J Thorac Cardiovas Surg* 77: 550-556, 1979.
2. Jensen MA, Petterson AH: Bronchial lipoma. *Scand J Thorac Cardiovas Surg* 4: 131-134, 1970.
3. Johansson L, Soderlund S: Intrathoracic lipoma. *Acta Chir Scand* 126: 558-565, 1963.
4. Koernschild HE, Marchall F, Andrews NC: Intrathoracic lipoma. Report of successful removal of a large tumor. *Ohio St Med J* 58: 1270-1272, 1962.
5. Leopold, RS: A case of massive lipoma of the mediastinum. *Arch Intern Med* 26: 274-278, 1920.

CMDNJ and Postgraduate Physician Training in New Jersey

CARTER MARSHALL, M.D., Newark*

For decades, New Jersey has relied on the recruitment of foreign medical graduates (FMGs) to fill its residency positions. During the 1960s 80 percent of all residencies were filled with FMGs. Today, the figure is only 56 percent and most of this reduction is directly attributable to the attractiveness of CMDNJ residency programs to American physicians.

Historically, New Jersey never has had the absolute shortage of physicians that plague our poor states like Mississippi or sparsely populated ones like North Dakota. However, more than any other state, New Jersey has for decades relied on the availability and importation of large numbers of foreign medical graduates.¹ Although this reliance has been greatly reduced in recent years, 56 percent of New Jersey residencies still are filled by FMGs. In the next highest state, New York, the proportion of FMG residents is 39 percent.

BACKGROUND

The heavy reliance on FMGs came about through the all too familiar vicious circle. Prior to the establishment of a state medical school, citizens of New Jersey were obliged to leave the State to obtain a medical education. Many remained out of state to complete their residency training and to practice. Unable to rely on a continuous flow of physicians educated in New Jersey, the State's teaching hospitals increasingly turned to foreign medical graduates. As residencies filled with FMGs, they became less attractive to Americans and the State came to be regarded as an undesirable place to train.

To attract American graduates New Jersey hospitals began to seek affiliations with medical schools in New York and Pennsylvania, some securing affiliations with as many as five different medical schools. By and large, this approach has

not been successful. Two-thirds of the residents in programs affiliated with out-of-state medical schools are foreign nationals, a higher figure than the average for the State. While many, if not most FMGs are good physicians who are capable of providing adequate care, their availability will be sharply curtailed over the next year or two due to the establishment of severe restrictions on their admission to this country and equally severe restrictions on their freedom to remain here permanently. Obviously, the supply of medical manpower, particularly in the primary care areas, is crucial to the continued well-being of our population and the implications of overdependence on FMGs are sufficiently clear to require no further comment.

ROLE OF CMDNJ

The purpose of this brief report is to describe the role of CMDNJ in producing physicians for New Jersey. Since its founding just over ten years ago, CMDNJ has managed to play a significant role in easing the State's medical manpower problems. As New Jersey residents emerged from the CMDNJ state medical schools, the number of FMGs began to decline and Americans began entering the primary care

*Dr. Marshall is Professor of Medicine and Director, Office of Primary Health Care Education, CMDNJ/New Jersey Medical School, Newark. He may be addressed there—100 Bergen Street, Newark, NJ 07103.

¹For purposes of this paper, a foreign medical graduate (FMG) is a non-U.S. national graduated from a foreign medical school.

**CONTRIBUTION OF CMDNJ TO POSTGRADUATE
PHYSICIAN TRAINING IN NEW JERSEY
SELECTED SPECIALTIES, 1979-1981***

College of Medicine & Dentistry of N.J. Programs

College of Medicine & Dentistry of N.J. Programs										Total CMDNJ Positions & % of Whole
Specialty	Total Positions	No. & (%) FMG	NJ Medical School		Rutgers Med. School		NJ School of Osteopathic Medicine			
			No. & % of Positions	No. & % FMG	No. & % of Positions	No. & % FMG	No. & % of Positions	No. & % FMG		
Internal Medicine	482	256(53)	148(31)	47(32)	52(11)	1(4)	23(5)	0	223(47)	
Family Practice	124	33(27)	0	0	7(6)	2(29)	0	0	7(6)	
Pediatrics	188	155(82)	124(66)	106(84)	25(13)	12(48)	4(2)	0	153(81)	
Ob/Gyn	98	35(36)	20(20)	9(45)	22(22)	3(14)	4(4)	0	46(47)	
TOTAL PRIMARY CARE	892	479(54)	292(33)	162(55)	106(12)	18(17)	31(3)	0	429(48)	
Psychiatry	82	57(70)	15(18)	13(87)	26(32)	1(6)	0	0	41(50)	
General Surgery	258	149(73)	87(34)	53(60)	26(10)	3(12)	10(4)	0	123(47)	
All Specialties	1735	970(56)	529(30)	278(52)	196(11)	31(16)	98(6)	0	823(47)	

*Table is a composite based on best available data over the period 1979-81. Primary source: Graduate Medical Education Survey 1978-79, Advisory Graduate Medical Education Council, Nov. 1979, 100 Bergen Street, Newark, N. J. 07103

specialties (medicine, pediatrics, family practice, and obstetrics) which represent the State's greatest need. The overall role of the College in physician training is presented in the table.

CMDNJ is now the primary supplier of American physicians for the state of New Jersey. Of its 823 residency positions, 514 or 62 percent are filled by Americans. In contrast, there are 912 non-CMDNJ residencies of which 261 or only 29 percent are filled by Americans. This difference is highly significant statistically ($p < 0.001$). CMDNJ-New Jersey Medical School in Newark is the State's largest producer of American born, American trained physicians. The proportions of FMGs in New Jersey Medical School residencies are higher than those at CMDNJ-Rutgers Medical School, but the Newark programs are larger. For example, the Department of Medicine at New Jersey Medical School alone produces more American internists for New Jersey each year than the total output of Americans completing residencies in all specialties at the largest private hospital in the State. Further, the physicians who complete CMDNJ-postgraduate programs are not lost to the State since physicians tend to remain where they do residency training.¹

Shortage areas are beginning to benefit. On July 1, 1981, twenty-one of the twenty-four graduates (88%) of the first class to complete the new CMDNJ-New Jersey School of Osteopathic Medicine started internships in South Jersey. In addition, on that same date, eleven graduates of CMDNJ-Rutgers Medical School (12%) began postgraduate training at Cooper Medical Center in Camden.

PRIMARY CARE SPECIALISTS AND FAMILY PRACTICE

In the primary care specialties, 58 percent of CMDNJ's 429 residency positions are filled by Americans (249 residents). Of the remaining 463 primary care positions in the State only 164 or 35 percent are filled by Americans. In the critical specialty of internal medicine, CMDNJ trains 47 percent of all the residents in the State and of these 223 physicians, 79 percent are Americans, compared to a proportion of only 20 percent or 51 Americans filling 259 remaining State positions. These differences in the primary care specialties and in medicine are also highly significant statistically ($p < 0.001$). The primary care residency programs are sufficiently large that CMDNJ-New Jersey Medical School accounts for half of all primary care positions in northern New Jersey even though the New Jersey Medical School does not offer a family practice residency.

With regard to family practice, the New Jersey Medical School is affiliated with the family practice residency program at Mountainside Hospital. Of 18 residents currently in this program, eight are graduates of the New Jersey Medical School (44%). Of the other family practice program in the area, Overlook Hospital, three out of 18 are New Jersey Medical School graduates. Rutgers Medical School has a new family practice residency program at St. Peter's Hospital in New Brunswick which presently has only seven residents but will grow to 24 in the next several years. In addition, Rutgers is affiliated with programs at Somerset, John F. Kennedy, and Hunterdon Medical Centers. The three pro-

"CMDNJ is now the primary supplier of American physicians for the state of New Jersey."

"FMGs increasingly are concentrated in surgery and its subspecialties, and in anesthesiology and pathology."

grams presently include 63 residents. These 63 plus seven in the St. Peter's program and the 18 in the CMDNJ affiliated program at Mountainside Hospital add up to 88 positions. Thus 71 percent of all family practice residencies in the State are offered by CMDNJ or programs affiliated with CMDNJ.

CMDNJ's success in attracting Americans to the primary care specialties has yet to be duplicated in other specialties. In surgery, for example, the proportion of Americans in CMDNJ and non-CMDNJ programs is virtually identical. As is true of the nation as a whole, FMGs increasingly are concentrated in surgery and its subspecialties, and in anesthesiology and pathology. Americans in contrast are found concentrated more and more in the primary care areas with the notable and disturbing exception of pediatrics and psychiatry.

There is no certain explanation for the declining attractiveness of pediatrics and psychiatry. Competition from family practice is often cited as well as long hours and relatively low income in the case of pediatrics and comparatively low income and the widely held notion that it is not "real" medicine in the case of psychiatry.

As FMGs become less available, the demonstrated attraction of CMDNJ training programs to American physicians

will benefit the State as a whole as efforts get underway to fill the gap left by the disappearance of FMGs.

SUMMARY

New Jersey's long reliance on foreign medical graduates to fill its residency positions peaked about a dozen years ago when FMGs comprised 80 percent of all housestaff. The preponderance of FMGs had a negative effect on American physicians who came to regard New Jersey as an undesirable place to train. This vicious circle was closed as lack of attractiveness to Americans reinforced the State's dependence on FMGs. The situation has improved dramatically over the past decade as CMDNJ began producing physicians. CMDNJ is now the State's primary supplier of American physicians. Sixty-two percent of its residency positions are filled by Americans as compared to only 29 percent among non-CMDNJ residencies. The differences are equally striking in family medicine, general internal medicine, general pediatrics, and obstetrics—the so-called primary care specialties. Here nearly 60 percent of CMDNJ positions are filled by Americans as opposed to 35 percent of positions elsewhere. Indeed, the Department of Medicine at CMDNJ-New Jersey Medical School produces more American internists each year than the total American output in all specialties at the State's largest private hospital. In addition, 71 percent of all family practice residencies in the State are offered by CMDNJ or by programs affiliated with CMDNJ. With the implementation of severe restrictions on both the admission to and length of stay of FMGs in the United States, foreign physicians no longer can be relied upon to fill gaps in medical manpower and the attraction of CMDNJ training programs to American physicians will be of still greater importance to the continued well-being of our citizens.

REFERENCE

1. Carnegie Commission on Higher Education: *Higher Education and the Nation's Health*. New York; McGraw-Hill, 1970.

"Americans . . . are found concentrated more and more in the primary care areas with the notable . . . exception of pediatrics and psychiatry."

"Here I was the first blind graduate of Juilliard and the only job I could get paid \$2.25 an hour."

"Most people express horror at the thought of being blind. I'm not knocking 20/20, but I would find it much more difficult not to have the use of my arms, legs or hearing."

When Valerie Capers was six years old she developed a strep throat and the virus settled in her optic nerve leaving her blind. Today she is an associate professor of music at Bronx Community College of the University of the City of New York.

She describes her first year at Juilliard as grueling, particularly at the end of the year performance exam. Each summer she would memorize music so that she could face the beginning of the school year with greater confidence.

After graduation, when she applied for a job teaching music at a neighborhood school, she was asked to audition for the parents. "If I were not blind, I would never have been asked to audition for that kind of job."

About the reaction to disabled people, she says, "people think, 'I'm glad it isn't me.' It arouses their fears and pity. Too often they consider the disabled a drag. They need enlightenment."

If anyone can contribute to that enlightenment, Valerie Capers can. Her zest for her work, her laughter, her professionalism and her impatience to get on with her work make the word "disabled" obsolete.



President's Committee on
Employment of the Handicapped
Washington, D.C. 20210

Produced by The School of Visual Arts Public Advertising System

Creation of a Loop Colostomy or Ileostomy with Immediate Application of Appliance

MARK J. PELLO, M.D., Camden
WILLIAM L. BEAUREGARD, M.D., Royal Oak, MI

Loop ostomies often are difficult to manage in the early postoperative period. The glass or plastic rod placed through the loop of bowel makes it difficult to obtain a good seal around the stoma with an appliance. A technique is described which allows for immediate application of a water-tight stoma appliance around a freshly created loop ostomy.

The value of both loop ileostomy and loop colostomy has been well established in the management of many surgical problems.^{1,2} A time-tested method of creating these loop ostomies has been to exteriorize a loop of bowel and pass a plastic or glass rod through the mesentery in such a fashion that the rod rests on the abdominal wall and prevents the bowel from dropping back into the peritoneal cavity. Several days after creation of the colostomy or ileostomy, when the bowel has become fixed in its position, the rod is removed. A problem which arises in the management of this ostomy during the interval that the rod is in place is leakage of stool onto the abdominal wall and nearby incision. The rod makes it very difficult to obtain a good seal around the stoma with an appliance.

METHOD

A method has been devised which allows a complete water-tight seal to be made around a newly fashioned stoma, while maintaining the benefits of a colostomy rod. A loop of bowel is brought through an incision about five centimeters in length in the abdominal wall in the usual fashion. Two small incisions, each about one centimeter long, are made on either side of the exteriorized loop of bowel. The small incisions are centered on the bowel mesentery about two centimeters away from the initial incision. A plastic rod is then passed through the mesentery of the loop of bowel. The two ends of the rod are then tunneled subcutaneously on either side of the main incision and brought out through the

two small counter incisions previously made. The rod now will prevent the bowel from dropping back into the peritoneal cavity but allows a complete circle of normal skin surrounding the ostomy stoma. The bowel is next opened



Figure 1—Loop colostomy (opened and matured) with rod placed in subcutaneous tunnel. Figure shows a ring of peristomal skin.

*From the Division of Colorectal Surgery, William Beaumont Hospital, Royal Oak, Michigan and CMDNJ—Rutgers Medical School, Cooper Medical Center, Camden, New Jersey. Correspondence may be addressed to Mark J. Pello, M.D., Colorectal Surgery, CMDNJ-Rutgers Medical School, 300 Broadway, 8th floor, Camden, NJ 08103



Figure 2—Loop colostomy with Karaya blanket^b applied to peristomal skin.

and the edges are immediately matured (Figure 1). A piece of Stomahesive^{®a} or a Karaya blanket^b is cut to conform to the size of the stoma and placed on the peristomal skin (Figure 2). An appliance such as a Bongort^{®c} bag is applied next and a completely waterproof seal is established (Figure 3).

SUMMARY

A technique has been described for creating a water-tight seal with an ostomy appliance around a freshly created loop ostomy. This simple technique has proved to be of great



Figure 3—Loop colostomy with adherent bag applied over Karaya blanket.^c

value in preventing fecal contamination of incisions in close proximity to newly formed loop ostomies.

REFERENCES

1. Maingot R: *Abdominal Operations*, 7th edition, Vol. II. Appleton, Century, Croft, New York, 1980, Chapter 150.
2. Sabiston D: *Textbook of Surgery*, 11th edition, Vol. I. Philadelphia, Saunders, 1977, pp. 1080.

^aE. R. Squibb and Sons, Inc., Princeton, NJ

^bHollister, Inc., Chicago, Ill

^cUnited Division of Howmedica, Inc., Largo, Fl

Selected Abstracts with Comments

Editorial: Aspirin (ASA) or acetaminophen (ACM). *Lancet* 2:287, 1981

Milligram for milligram ASA and ACM have the same antipyretic and analgesic effects. ASA has greater anti-inflammatory activity but ACM has substantial effect. ASA and ACM therefore are essentially equal and safety usually should decide between the two. ACM is undoubtedly safer. ASA affects the stomach (mucosal damage), hemostasis (inhibits platelet aggregation), kidneys (papillary necrosis), fetus (labor prolongation, persistent fetal circulation), liver (hepatitis), brain (Reye's ?) and can cause insidious overdosage in infants due to metabolic differences in elimination. ACM on the other hand in usual dose is among the safest of drugs. Its only "defect" is the hazard of acute hepatic necrosis in poisoning. ACM should be the drug of choice as an antipyretic and analgesic, especially for children.

Comment: Ditto. When used for comfort of the child, ACM is a safe and effective drug. Under age six months, however, I remain insecure.

Mofenson HC et al: Baby powder, a hazard! *Pediatr* 68:266, 1981.

Forty cases of baby powder aspiration were reported to the Nassau County Poison Center in six months. There is no proven medical indication for its use.

Comment: The authors point out that the ingredients of commercial talcum (silicates) can cause fatal aspiration. Containers should be made childproof and parents should be warned.

Brook I et al: Aerobic and anaerobic bacteriology of cutaneous abscesses in children. *Pediatr* 67:891, 1981

Two hundred nine cutaneous abscesses in children were carefully cultured. None of the abscesses was related to bites. *S aureus* (almost all penicillin resistant) predominated on the extremities, neck and trunk. Gram-negative aerobes (*E coli* et al) predominated in perineal, perirectal and buttock areas. Anaerobes frequently were found in these latter areas as well as the head, fingers and the nailbed (paronychia).

Comment: The finding of anaerobes in perioral, finger (to mouth) and perineal-perirectal areas is not surprising. Antibiotic treatment for those abscesses needing same (rather than drainage alone) should take into account the expected flora.

Tully JL et al: Complications of IV therapy with steel needles and teflon catheters. *Am J Med* 70:702, 1981; **Birnbaum DW: Safety of maintaining IV sites for longer than 48 hours.** *J Clin Microbiol* 13:833, 1981

Teflon catheters have a substantially greater risk of phlebitis than steel needles but steel needles have a much greater incidence of infiltration. When teflon catheters are used for more than 48, and especially more than 72 hours,

the IV infection rate becomes appreciable.

Comment: Whether one uses teflon catheters or steel needles, the rule should be to limit their duration to 48 to 72 hours.

McNeil BJ et al: A prospective study of computed tomography (CT), ultrasound (US) and gallium imaging (Ga) in patients with fever. *Radiol* 139:647, 1981

A large study of patients with postoperative fever, acute fever of unknown origin and prolonged fever revealed that these three modalities were complementary. If any two were used and only one was abnormal, sensitivity increased from 60 to 90 percent but false positive also increased. If both modalities were abnormal, false positives were nearly zero percent but sensitivity fell to 40 percent. "... all three modalities have a similar ability to detect sepsis ... sensitivity can be increased by using any two of them."

Comment: The authors point out that one should use common sense. The initial exam for someone with focal abdominal tenderness might be CT or US, while without focal findings Ga might be considered.

Hatch EI et al: Pitfalls in the use of barium enema in early appendicitis in children. *J Pediatr Surg* pp 309-312, 1981

Appendicitis remains the most common intra-abdominal indication for surgery in children. Barium enema has been helpful in increasing the accuracy of diagnosis in difficult cases. Two hundred two barium enemas in children with possible acute appendicitis were performed. Of the 66 children who underwent surgery, there were 32 children who had a positive barium enema, and 31 of these turned out to have acute appendicitis.

Comment: In the group that had negative barium enemas, there were three false negatives, and two of these children had early perforations by the time of their surgery. The third group were equivocal barium enemas and these cases revealed the difficulty in verifying a non-inflamed appendix. In conclusion, positive barium enema is helpful, but negative barium enema could not be relied upon to delay surgery in the child with right lower-quadrant peritoneal signs. (S. Saad, M.D.)

Knicht PJ et al: Specific diseases mimicking appendicitis (Ap) in children. *Arch Surg* 116:744, 1981

Eleven percent of more than 1000 children with a pre-

*Abstract from the *Department of Pediatrics Newsletter*. CMDNJ, New Jersey Medical School, Newark—Vol. 3 No. 9 (Sept.) 1981. Selections are made by Richard H. Rapkin, M.D., Professor of Pediatrics and Medical Director of Children's Hospital, Newark, who is editor: Franklin C. Behrle, M.D., Professor and Chairman of Pediatrics, and Shyan C. Sun, M.D., Associate Professor of Pediatrics and Director, Department of Neonatology, Children's Hospital, Newark, who are coeditors. Comments are prepared by them and their associates.

operative diagnosis of Ap did not have Ap. Half of these children had a specific other diagnosis including ovarian torsion or cyst, primary peritonitis, omental infarct, perforated Meckels or salpingitis. Other children had essentially no findings (several called mesenteric adenitis).

Comment: This study revealed that in a careful service approximately 10 percent of children explored for Ap will not have that disease, and half of those will have another specific diagnosis. Only one of 20 children explored for Ap will have no specific disease found. These results are laudable and we all should strive to emulate them.

Black RE et al: Handwashing to prevent diarrhea in day-care centers. *Am J Epidemiol* 113:445, 1981; Pickering LK et al: Diarrhea caused by shigella, rotavirus and giardia in day-care centers. *J Pediatr* 99:51, 1981

In a carefully controlled study, handwashing by employees (before handling food, upon arrival, upon helping child use toilet) and by children (upon arrival, when using the toilet) was associated with a modest but significant decrease in diarrhea among children. In another study many usual pathogens were identified as causing diarrhea in day-care centers. Children were not excluded even when ill with diarrhea and no policy existed in most centers regarding exclusion and readmission. Household contacts of children acquired the illness frequently.

Comment: Day-care centers need to establish policies for preventing transmission of contagious disease.

Fisher M et al: Gallbladder disease in children and adolescents. *J Adol Health Care* 1:309, 1981

Eighty-five children and adolescents with gallbladder disease were reviewed. The summary of the study was as follows:

Etiology	Group I (65 patients)	Group II (20 patients)
	Idiopathic	Secondary to predisposing disease
Sex	92.3% female	45% female
Age	100% above 12 years	60% less than 13 years
Weight	60% overweight	15% overweight
Family history	20% positive	5% positive
Previous pregnancy	27.7% positive	0%
Symptomatology	Same as adults	—
Diagnosis	Delayed	Early

These data indicate that children and adolescents with gallbladder disease constitute two distinct populations, and that idiopathic cholelithiasis and cholecystitis must be considered as a potential cause of chronic abdominal pain in otherwise healthy adolescents.

Comment: Agree!! (S. Saad, M.D.)

Editorial comment: These data surprised me. It is quite clear that gallbladder disease in childhood is not only found in patients with hemolytic anemia. Idiopathic cholecystitis and cholelithiasis indeed occurs during adolescence. The frequency is relatively low (85 patients in 19 years at Long Island Jewish Medical Center).

Simeone JF et al: New trends in gallbladder imaging. *JAMA* 246:380, 1981

Real-time sonography is probably the preferred method (1981) for elective screening of the gallbladder in patients suspected of chronic cholecystitis and cholelithiasis. Acute cholecystitis can be reliably diagnosed using ultrasound and radionuclide scintigraphy (using technetium 99m iminodia-

cetic acid, TcIDA). Oral cholecystography still may have some value but is used less frequently since a normal oral cholecystogram may miss small calculi.

Comment: The accuracy, ease of performance, lack of radiation and speed of ultrasonography argue for its use as the initial evaluating tool. The TcIDA scan has its greatest use in proving patency or obstruction of the cystic duct.

Leape LL et al: Esophageal biopsy in the diagnosis of reflux esophagitis. *J Pediatr Surg* 16:379, 1981

Esophagitis in infancy and childhood produces characteristic histologic changes (mixed inflammatory infiltrate and basal cell hyperplasia) in the mucosa and lamina propria of the distal esophagus. The use of biopsy in addition to endoscopic evaluation considerably enhances the accuracy of diagnosis of esophagitis, particularly when the degree of inflammatory change is mild. In the absence of severe inflammatory changes such as ulceration or mucosal slough, esophageal biopsy appears to be essential for the accurate diagnosis of esophagitis. In children of any age with gastro-esophageal reflux who have symptoms of esophagitis, antacid therapy and rigorous efforts to control reflux are indicated. Failure to respond to this problem is an indication for esophageal biopsy to confirm or rule out the presence of esophagitis. The degree of inflammatory change is a reliable guide to expected response to antacid therapy.

Comment: This paper describes, illustrates and gives criteria for the grading of pathologic changes in reflux esophagitis. It furthers shows that endoscopic findings correlate poorly with the biopsy results particularly when the esophagitis is mild to moderately severe; for example, of 31 patients judged to have normal esophagus by endoscopy, 18 had histologic findings of significant inflammation. More significantly, histologic findings correlated with response to therapy. While the medical therapy was successful in patients with mild grades of inflammation, no patients with Grade III or Grade IV inflammation as seen on biopsy responded to medical treatment. About 50 percent of these patients ultimately required an antireflux operation. Thus esophageal biopsy appears to be an important diagnostic procedure in certain cases of gastroesophageal reflux. (V. Joshi, M.D.)

Walsh JK et al: Gastroesophageal reflux (GER) in infants: Relation to apnea (A). *J Pediatr* 99:197, 1981

Fourteen infants with GER and A were studied to determine whether GER and A were related. A was equally likely to occur during non-GER times as during GER. GER and A both may be manifestations of developmental delay rather than related as cause and effect.

Comment: Significant GER is uncommon. Its association with other neurological and developmental disorders suggests a common etiology—variant of cerebral palsy (bulbar).

Wilkinson JD et al: A comparison of medical and surgical treatment of GER in severely retarded children. *J Pediatr* 99:202, 1981

Seventy-four percent of retarded children with GER failed to respond to medical therapy. Surgical treatment, although associated with frequent complications, was more likely to lead to relief of symptoms of GER.

Comment: GER in retarded children is often a more severe disease and may require aggressive surgical management despite frequency of complications. The association of GER and MR strengthens the theory noted above.

“Pro-Competition”: Panacea for Rising Health Care Costs or Just the Opposite?

Just as Wall Street's spring euphoria over Reaganomics faded into the September blues, so the uncritical enthusiasm with which segments of the health care establishment greeted the new administration's approach to health care policy has shifted to cautious skepticism. This is understandable. Despite all the welcome rhetoric with respect to reducing federal regulations, there are very few facts to go on; and these are, in many respects, contradictory. For example, the prospect of relief from some burdensome PSRO and HSA activities may be more than cancelled by concern over payment for future Medicaid and other low-income uninsured patients.

HEALTH CARE POLICY AND PROPOSED LEGISLATION

With respect to the centerpiece of the administration's health care policy—its overall “reform act”—the only hard fact thus far—more than a year after the President's people began studying the subject and nearly a year after the election—is the total absence of any definitive legislative proposal. This is not only reminiscent of the long delay and final abortion of the Carter administration's efforts to produce a definitive overall national health policy, but also testimony to the extreme difficulty of coming up with any politically or administratively realistic proposal, regardless of ideological orientation.

This does not mean, however, that we are totally in the dark as to the administration's intentions. On the contrary, most of those in the relevant leadership positions have already made clear their general philosophy, goals and even the most desirable (from their point of view) means of achieving these goals. David Stockman, Director of the Office of Management and Budget; Richard S. Schweiker, Secretary of Health and Human Services; Senator Orrin G. Hatch, Chairman, Senate Labor and Human Resources Committee; Senator David Durenberger, Chairman, Senate Finance Subcommittee on Health; Representative Richard A. Gephardt, Chairman, House Budget Committee Task Force on Human Resources and Block Grants all have sponsored major bills in the 96th or 97th Congress, or both.

Although there is virtually no chance of any of these bills being enacted in anything like their present form, they serve a useful purpose as a guide to administration intentions. It should also be noted that the administration's “pro-competition” philosophy now has attracted considerable bipartisan support.

1. *The Comprehensive Health Care Reform Act of 1981 (S. 139)* introduced by Senator Hatch, formerly Senator Schweiker's bill.

2. *The National Health Care Reform Act of 1981 (H.R. 850)*

introduced by Representative Gephardt and essentially the former Gephardt-Stockman Bill.

3. *The Health Incentives Reform Act of 1981 (S. 433)* introduced by Senator Durenberger.

4. *The Voluntary Medicare Option Act (H.R. 4666)* introduced by Representatives Gephardt and Gradison, October 2, the latest proposal of this type.

H.R. 4666 is confined to Medicare, reflecting the administration's greatest sense of urgency. It also takes into account some of the major criticisms leveled at the earlier bills. In general, however, its aim is basically the same as that of H.R. 850, i.e., to encourage as large a proportion of the population as possible to switch from the government program to a competitive, privately-operated, HMO-type plan. In this case, the Medicare population, except those with end-stage renal disease and/or Medicaid-eligibles, is the target. Open enrollment periods would be held annually. Although a qualified plan must agree to provide services at least equal to those now provided by Parts A and B, there is a complicated cost-sharing formula based on a “maximum permissible financial participation amount” to be determined annually by the Secretary of Health and Human Services (HHS).

While the four bills differ in many other respects, some of which will be noted below, they share a common theme which distinguishes them sharply from most of the National Health Insurance proposals of the past. In a sentence, the earlier goals of increasing public access to care and improving the quality of such care have been abandoned in favor of the single overriding goal of cost containment, especially at the federal level. To achieve this, the new “pro-competition” advocates seek to restructure the health care marketplace by forcing more competition among third-party insurers who, in turn, would be expected to press for more competition among the providers. They also seek to reduce the proportion of the national health care dollar covered by third-party payment and to increase the portion met by the patient at the time of use. The overall strategy is to force the consumer/patient to be extremely cost conscious and frugal in selecting an insurance plan and/or to partake of comparison shopping among providers at the time of illness.

Clearly, the new approach involves a great deal more than economics. It involves life and death issues so complex and so basic to the public welfare that they defy rapid comprehension. I will try to identify a few of these issues. Both individual physicians and the Medical Society of New Jersey should examine the whole matter in depth. Copies of the four proposals can be obtained from the offices of the respective sponsors. Two brief but useful analytical brochures (single

copies) are available free:^a

As its first major proponent, Alain C. Enthoven of Stanford University made a strong defense of the "pro-competition" position.⁷

Most of the following discussion will focus on the three earlier bills which have been studied carefully by analysts with widely differing backgrounds.

MAJOR ISSUES IN NATIONAL HEALTH CARE POLICY AND CURRENT PRO-COMPETITION PROPOSALS

1. **Universal financial access to needed health care**—Only the Gephardt Bill (H.R. 850) even attempts to address this issue. S. 139 and S. 433 leave Medicare and Medicaid unchanged in this respect and, presumably, the 25 to 30 million Americans, who currently have no third-party protection, would remain that way.

H.R. 850 provides that every person be eligible for a uniform "health care contribution" to be determined by the Secretary of HHS. For the employed, this contribution would come from employer and/or employee tax-deductible contributions, up to a defined limit. Beginning in 1984, Medicare beneficiaries would be provided vouchers equal in value to the "health care contribution" for the employed, with which they could enroll in a private health care plan. As soon as more than half of all Medicare beneficiaries opt out of the government plan, Medicare would be repealed. Also, beginning in 1988, at state option, the poor and unemployed would also receive vouchers, as alternatives to Medicaid, with which they could enroll in a plan. However, the proposed value of the vouchers would be substantially less than existing Medicare benefits. Moreover, vouchers do not guarantee the existence of a qualified plan. Critics fear this could turn out to be an empty promise, possibly leading to a new version of the old "Medicaid mills," and thus perpetuating or even exacerbating a two-tier health care system.

2. **Benefits**—Insofar as categories of benefits are spelled out, there is little improvement over Medicare. Long-term care remains excluded in all the bills. S. 139 requires that all employers of 50 or more employees must add "catastrophic" coverage, prescription drugs and defined preventive services. H.R. 850 calls for coverage of prescription drugs and services for children. Mental health services specifically are excluded.

To qualify for catastrophic benefits, all three bills require high deductibles and/or coinsurance. S. 433 provides a \$3500 annual out-of-pocket deductible; for H.R. 850, the deductible is \$2900. S. 139 calls for coinsurance of 25 percent up to 20 percent of earned family income. These provisions, combined with the heavy emphasis on low-price premiums, emphasize the effort to reverse the basic concept of insurance—sharing of risks—and to restore individual financial responsibility insofar as possible, especially for the lower-cost services, such as ambulatory care. It is diametrically opposed to the popular consumer drive for first-dollar coverage and recent professional efforts to encourage prevention, early detection and treatment of disease.

3. **Financing**—S. 139 and S. 433 follow the current predominant pattern of health insurance financing, i.e., through employer and/or employee contributions. However, both severely would limit the tax-deductible amount that either

party could contribute. In both cases the maximum employer contribution, if any, must be uniform for all plans offered. According to S. 139, it cannot be higher than the premium cost of the most expensive group plan in which at least ten percent of the employees are enrolled. S. 433 provides for annual promulgation of monthly "indexed contribution amounts." First year monthly figures would be \$50 for an employee, \$125 for a family. Any employer contribution over these figures would be taxable and also would be included in employee gross income for income tax purposes, as would any employer contribution to a noncomplying health insurance plan.

H.R. 850 departs most radically from current practices. It too calls for a maximum on the amount that an employer can contribute on behalf of his employees prior to being subject to corporate and individual employee taxes, but leaves the determination of this figure to the Secretary of Health and Human Services. In addition, all further connections between the employee's insurance and the employer would be severed. The employer's only responsibility would be to inform employees as to the amount of the company's monthly contribution which—to be tax-deductible—must be within limits fixed by the Secretary, and to issue to each employee an identifying certificate which he or she would then use to purchase any qualified plan on the open market. Employer self-insurance would be impractical.

All three bills provide that employees selecting plans less expensive than the government-determined employer contribution limit would be rewarded by a cash rebate (generally tax-deductible) or additional benefits. The clear objective of these provisions is to induce the employee to choose the least expensive plan and to prevent the employer from helping him buy a more expensive one. Employees selecting more comprehensive coverage not only would pay the higher price but also would have to pay taxes on the additional outlays required to buy the higher priced coverage.

4. **Carrier competition/consumer choice**—As already noted, the Gephardt Bill permits everyone, employed and unemployed, rich and poor alike, to choose from among all the available qualified plans. All persons theoretically would have the standard "health care contribution" certificate or, in the case of the poor, a voucher, to use for payment. Under the other two bills, the choice could be somewhat more restricted, but each requires larger employers to make available at least three different qualified plans.

In some respects, this is positive for it frees the employee from any dependence on employer or union preferences (which at times may be self-serving), and it reduces the traditional advantage of employees who work for larger or more profitable firms. There are a number of serious problems, however. Many employees are informed inadequately and otherwise unprepared to make the wisest choice. "Adverse selection" inevitably will be a major problem. Younger and healthier individuals will tend to choose the less expensive plans, leaving the older and less healthy to pay the penalty for more expensive coverage.

This problem could be minimized by outside evaluation and restriction of the number of qualified plans and perhaps some requirements as to demographic and other socio-economic mix. But this in turn flies in the face of the proponents' general commitment to the least possible administration or regulatory interference with the "free market."

5. **Administration**—Administrative details are extremely sketchy in all the plans. In general, the intent is to leave as

^aCompetition and Consumer Choice: National Health Care Legislative Proposals. The Blue Cross and Blue Shield Association, 1700 Pennsylvania Avenue, N.W., Washington, DC 20006

Competition in the Health Care System: An Evaluation of the Pro-Competition Bills. Health Insurance Association of America, 1850 K Street, N.W., Washington, DC 20006

much discretion as possible to the individual carriers. The Secretary of HHS generally is expected to determine which plans qualify and IRS or the Treasury to administer the tax provisions. Gephardt establishes a federal Health Benefits Assurance Corporation in the Treasury to certify and monitor plans and to provide for arbitration of enrollee grievances under a U.S. Health Court.

This is obviously an area of minimal concern to the proponents of these bills. For example, the idea of one court, presumably in Washington, to review claims and grievances for some 230 million Americans is absurd to the point of nonsense.

6. **Costs**—A Congressional Budget Office staff paper estimates that H.R. 850 would cost the federal government almost \$15 billion additional in FY 1984.¹ The new tax credits, for those with no current health insurance or less than the federal target under the bill, are estimated to cost about \$19.4 billion that year, as against about \$4.9 billion in increased revenues resulting from taxing "excess" employer health insurance contributions.

7. **Quality of Care**—There appear to be no provisions in any of these bills relating to either the definition or control of quality. On the contrary, the heavy emphasis on price and strong inducements to the consumer to buy the cheapest possible coverage are likely to militate against quality. Proponents correctly claim that quality and economy/efficiency are not necessarily antithetical, and that existing health insurance coverage frequently has led to higher price without any real improvement in quality. Critics say that the new bills err on the opposite side and discriminate against quality.

8. **Teaching hospitals and regionalization of care**—Currently, there are no special provisions for higher rates for teaching hospitals or other tertiary institutions. The pro and con arguments are similar to those in No. 7 above. Existing open-ended reimbursements to such institutions, at times, have been abused. However, there is a difference in the care that is, or should be, rendered in a teaching hospital or a regional tertiary institution. It relates to teaching and research, to the degree of specialization of both personnel and equipment and to the fact that many teaching hospitals are required, as a result of geographic location or other reasons, to serve a disproportionate proportion of the poor. For example, College Hospital in Newark reports that 34 percent of its patients are "indigent," i.e., they lack not only Medicare and private health insurance, but even Medicaid. Could this type of hospital survive in a competition based strictly on price?

9. **Effect on local medical practice**—It is impossible to predict exactly how the "pro-competition" scenarios would affect individual physician practice and income. As noted, the clear intent is to restrain the rise in health care costs by forcing providers to compete vigorously for their patients. Proponents believe this can be done primarily by forcing more effective organization of health care delivery, e.g., through HMOs or other health care "systems," and by removing the "perverse incentives" to overuse said to be inherent in fee-for-service reimbursement.

While it is doubtful that any such drastic restructuring of the U.S. health care system is possible—let alone desirable—in the foreseeable future, there is little question but that passage of any of these bills, especially H.R. 850 and/or H.R. 4666, would tend to further competitive pressures already visible in the current emphasis on "hospital marketing," provider advertising, and the phasing-out of PSROs

and health care planning. Indeed, some authorities on health manpower believe that, with or without the proposed bills, much greater competition is inevitable simply on the basis of the anticipated dramatic rise in the physician/population ratio over the coming decade. Such competitive pressures may well affect the interrelation of various specialties, of specialists and generalists, of U.S.-trained and foreign-trained graduates, of academic and community physicians and hospital-physician relations, as well as the attractiveness to physicians of HMO employment.

The increasingly negative attitude on the part of most of the major interest groups was described by John Iglehart.² Among those that are having serious second thoughts or concerns regarding the "pro-competition model," Iglehart names the American Medical Association, Health Insurance Association of America, Blue Cross/Blue Shield, the Washington Business Group on Health (the AFL-CIO has been opposed all along), and even the Group Health Association of America, the national lobby for HMOs.

According to Iglehart, who is the director of the Kaiser Foundation Health Plan's Washington office, the GHAA "is troubled by the potential impact of an approach to competition that emphasizes lean benefit packages or plans covering catastrophic care only, coupled with tax rebates that reward people for underinsuring, fragment the base for spreading health-care costs, and intensify the problem of adverse selection." Only two groups—Federation of American Hospitals, the national lobby of for-profit hospitals, and the National Council of Community Hospitals, an organization of 110 nonprofits, were reported as still staunchly behind the new approach. However, President Alex McMahon of the American Hospital Association, testified in a generally favorably vein at the House Ways and Means Committee hearings, September 30.³

Editorializing in the *American Journal of Public Health*, Steven Schroeder, of the University of California—San Francisco, speculates that the present administration's approach to health care may result not only in increased public cost consciousness but also in accelerated growth in costs and thus lead to a revitalized coalition for national health insurance.⁴ As if to underscore such a possibility, the same day's mail brought a pamphlet from the AFL-CIO's Committee for National Health Insurance—Health Security Action Council condemning the "pseudo health competition bills"⁵ and the September 18 issue of the *AMA News* featuring Dr. Sammons' highly critical speech to the American Hospital Association's recent convention in Philadelphia.⁶ Both singled out H.R. 850 for special attack.

Despite the growing criticism, Iglehart concludes that the tremendous pressure on the social side of the federal budget, resulting from the President's tax-cutting program coupled with his commitment to a balanced budget and a vastly expanded military buildup, will continue to force consideration of the new approach. In his words, "The Reagan administration believes that health-care competition is the answer to checking the uncontrollable spiral in health-care spending. As a consequence, and in the light of the diminished faith in increased government regulation as a solution, the competitive model very rapidly has become the standard against which all interests, public and private, must measure their alternatives in the coming debate."

CONCLUSION

Among the alternatives no longer available, I submit, is the complacent belief that the health care establishment will

weather this ideological storm, more or less intact, just as it did the storm over National Health Insurance a decade earlier. This is no longer a viable option. In one way or another, crudely and cruelly if not wisely, cost controls will be applied. The alternative to the administrative nightmare that could emerge from these ill-conceived plans has to include some effective approaches to cost restraints. Among these, negotiated fee-schedules for physicians, prospective rates for hospitals, some nondeterrent cost sharing for patients, and some amendments to the existing tax laws appear to be reasonable and not seriously damaging either to physicians or patients. For the long run, much growing public and professional attention to prevention and to home- and community-based alternatives to institutional care, for the growing legion of the elderly and chronically disabled, is essential to any viable health care policy.

REFERENCES

1. Congressional Budget Office: *Analysis of the National Health Care Reform Act of 1981*. Washington, DC, 1981.
2. Iglehart JK: Drawing the lines for the debate on competition. *N Engl J Med* 305: 291-296, 1981.
3. McMahon calls consumer plans promising options. American Hospital Association, *Hospital Week*, October 2, 1981, p. 1.
4. Schroeder SA: National health insurance—always just around the corner? *Am J Pub Health* 71: 1101-1103, 1981.
5. Committee for National Health Insurance—Health Security Action Council: *Pseudo Health Competition Bills—The "Have-Less" Insurance Approach*. Washington, DC, 1981.
6. Top AMA leader assails Gephardt's "competition" plan. *AMA News*. September 18, 1981, p. 1.
7. Enthoven AC: The competition strategy: Status and prospect. *N Engl J Med* 304: 109-112, 1981.

Anne R. Somers

Department of Environmental and Community Medicine
CMDNJ, Rutgers Medical School

216th Annual Meeting May 14-17, 1982 Resorts International, Atlantic City Daily Schedule

Friday, May 14, 1982

- 3:30 p.m.—Board of Trustees' Meeting
- 5:00 p.m.—Delegate Registration

Saturday, May 15, 1982

- 7:30 a.m.—Delegate Registration
- 9:00 a.m.—House of Delegates
- 9:00 a.m.—Message Center, Exhibits, Auxiliary Arts and Hobbies Open
- 10:30 a.m.—House of Delegates (election)
- 12:00 noon—Golden Merit Award Ceremony followed by Reception for Award Recipients and their Families
- 1:00 p.m.—Reference Committee Meetings: "A", "B", "C", "D", "E", "F", "G", "H", Constitution and Bylaws
- 6:00 p.m.—JEMPAC Wine and Cheese Reception

Sunday, May 16, 1982

- 7:00 a.m.—JEMPAC Breakfast
- 8:00 a.m.—Registration Opens
- 9:00 a.m.—Message Center, Exhibits, Auxiliary Arts and Hobbies Open
- 9:00 a.m.—Scientific Sessions
 - Allergy; Chest Diseases; Cardiovascular Diseases; Emergency Medicine; Family Practice; Medicine; Orthopaedic Surgery; Pediatrics; Psychiatry; Surgery; Clinical Pathology; Oncology

11:30 a.m.—Luncheon

1:00 p.m.—Scientific Sessions

Spencer T. Snedecor Trauma Orator:
Anesthesiology; Dermatology; Gastroenterology and Proctology; Clinical Pathology; Neurosurgery and Neurology; Nuclear Medicine, Radiology; Obstetrics and Gynecology, Urology; Ophthalmology; Otolaryngology—Head and Neck Surgery; Physical Medicine and Rehabilitation; Plastic and Reconstructive Surgery; Rheumatism

4:00 p.m.—Annual Meeting—Board of Governors of MIE

6:30 p.m.—Inaugural Reception

8:00 p.m.—Inaugural Dinner

Monday, May 17, 1982

- 6:30 a.m.—Essex County Breakfast Caucus
- 6:30 a.m.—Union County Breakfast Caucus
- 8:00 a.m.—Registration Opens
- 9:00 a.m.—Message Center, Exhibits, Auxiliary Arts and Hobbies Open
- 9:00 a.m.—House of Delegates (to consider Reference Committee reports)
- 12:00 noon—Message Center, Exhibits, Auxiliary Arts and Hobbies Close
- 12:00 p.m.—House of Delegates adjourns for lunch
- 1:30 p.m.—House of Delegates reconvenes
- 4:00 p.m.—House of Delegates adjourns
- 7:00 p.m.—Board of Trustees' Dinner-Meeting

DOCTORS' NOTEBOOK

Trustees' Minutes September 20, 1981

A regular meeting of the Board of Trustees was held on Sunday, September 20, 1981 at the Executive Offices in Lawrenceville. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Proposed Regulation on Schedule II Drugs . . . Directed that MSNJ's objections to a proposed regulation on Schedule II drugs [which will require physicians in New Jersey who prescribe Schedule II narcotic medication for a patient for a stated number of days during a calendar year to provide certain information from the patient's record to the State Board of Medical Examiners] be documented and forwarded to the State Board of Medical Examiners, the American Civil Liberties Union, the New Jersey Public Advocate, and that the membership be advised through the *Membership Newsletter* to submit their individual comments on this proposal to the State Board. Strong opposition to the proposal was expressed by the Board of Trustees.

Note: The regulation raises the question of the State Board's legal authority to create a requirement which effects a breach of physician-patient confidentiality. The report requirement is ambiguous and places an undue burden on physicians and is a hazard to their patients. It is virtually impossible in New Jersey to enjoin an administrative agency from adopting a rule. It is possible to litigate after the rule has been applied and it can be shown that it constitutes an unreasonable practice or violates statutes. The first step, therefore, is to submit written comments to the State Board on the legality and wisdom of the proposal so as to establish a record of the Society's posture on the ruling in the event litigation is initiated.

Proposed Legislation by Attorney General . . . Approved a recommendation that the Board of Trustees withhold action, until the actual wording of the legislation is documented, on a proposed program of the Attorney General [concerning impaired physicians and physicians who demonstrate gross in-

competence or negligence or commit other violations], which includes the introduction of legislation to require all practicing professionals to report impaired colleagues to the Board of Medical Examiners and to require insurance companies to report all professional liability claims to the State Board.

Note: A consensus was reached on the impaired-physician concept but there is serious concern on legislation that would require the reporting of open liability claims or suits to the regulatory agency.

State Board of Medical Examiners vs. Greco . . . Received as informational a report that the Appellate Division of the Superior Court reversed the decision of the State Board of Medical Examiners which issued a summary suspension of a physician's license, charging him with being a critical and eminent danger to public health.

Note: The case involved the medical director of Essex County Hospital (a nursing care facility) who was accused of gross negligence because five elderly patients with histories of chronic illness and disease were not transferred to an acute-care hospital. The Appellate Division ruled that a summary action was not warranted and the case was remanded to an administrative law judge.

MSNJ Membership . . . Noted that as of August 31 MSNJ paid membership totaled 7,529, which is 71 below the number on which the budget was computed. The financial deficit should be made up from income from non-dues sources.

Gubernatorial Reception . . . Approved a recommendation to hold a gubernatorial reception after the election. The concept is to have the new Governor meet with representatives of the medical profession to discuss plans of his administration. Refreshments and entertainment would be provided; the fee would be \$15 per person or \$20 per couple. The cost to the Society above the anticipated amount to be collected is not expected to exceed \$3,000.

New Jersey State Medical Underwriters

1. Computer Software . . . Noted that when a proposal has been made concerning the question of property rights to computer software, a report will be made to the Board.

2. Rate Filing . . . Noted that the Insurance Commissioner has not acted on the rate filing which was to be effective as of February 1, 1981, and approval of that filing does not appear probable.

Executive Coordinator for Committee on Impaired Physicians . . . Authorized MSNJ to expend money this year for office space, secretarial personnel and travel expenses to support the program of the Committee on Impaired Physicians.

Note: The Board has approved the acquisition of a fulltime coordinator for the Committee with the understanding that the financing would be obtained from other sources. Commitments to provide \$50,000 per year have been made by the Medical Inter-Insurance Exchange of New Jersey and the New Jersey Hospital Association.

CMDNJ . . . Received a report from the President of the College of Medicine and Dentistry of New Jersey which included a summary of the past year's achievements and goals for the coming year and revealed that tuition is now \$5500, that 44 osteopathic freshmen are enrolled, that the allopathic program operated by CMDNJ-Rutgers Medical School in connection with Cooper Medical Center will enroll 40 freshman and that the official ground-breaking for the clinical educational facility in Camden was scheduled for October 6.

MSNJ Student Association:

1. Student Financial Aid Program . . . Approved the following recommendations concerning MSNJ's role in designing equitable financing of a medical education:

(a) That the Board of Trustees endorse the concept of state level service-contingent loans and assist the Student Association in having such a program introduced in the New Jersey State Legislature with active support from the Medical Society. (Model legislation exists, and the plan will be made available to the Board.)

(b) That the Board of Trustees charge the Committee on Medical Education to monitor

federal and state aid packages [such information is available from the Association of American Medical Colleges] and periodically recommend positions on the various federal and state programs, as they expire and are amended, to insure adequate access to medical education without financial barriers or unreasonable payback plans.

2. MSNJ's Student Medical Loan Fund ... Approved the following recommendation concerning applicants for MSNJ's Medical Student Loan Fund:

That membership in the Medical Society of New Jersey Student Association be required to apply for a loan through the Medical Society of New Jersey Student Loan Fund. Students attending a medical school which does not have an active chapter in the Student Association could join directly through the Executive Offices of the Medical Society in Lawrenceville.

Council on Legislation:

1. Referrals from the 1981 House of Delegates—

(a) Term of service on the State Board of Medical Examiners—Resolution #24:

RESOLVED, that no member of the State Board of Medical Examiners serve more than two consecutive three-year terms, and, to preserve continuity, the terms of all members should be staggered.

... Approved a recommendation that a "white paper" be prepared for presentation to the Governor and the New Jersey State Legislature covering the statement in the resolution and noting also that MSNJ's position is that any physician-member of the State Board of Medical Examiners should be engaged in the clinical practice of medicine, i.e., patient or consultative services, that MSNJ should have input on proposed physician membership and that the gubernatorial candidates should be apprised of MSNJ's position.

(b) Statute of Limitations—Resolution #28:

RESOLVED, that the Medical Society of New Jersey draft appropriate legislation and cause such to be introduced in the Legislature, attempt to obtain a reasonable and strictly defined Statute of Limitations.

... Noted that the Council had agreed with the Board's recommendation (May 15, 1981) that the staff of MSNJ and MILE-NJ join efforts to develop a legislative package dealing with the key areas. A full report is to be made to the Board.

2. Parental Notification Prior to the Per-

formance of an Abortion—A-1155—Lesniak ...

Noted that the Council reaffirmed its position of active opposition to A-1155 which requires a physician to give 24-hours notice to parents, *et al.*, before performing an abortion on an unemancipated minor under 18.

Note: Council on Legislation previously had opposed this bill because it presents a conflict of law—a pregnant woman already has been declared an emancipated minor under Title IX of the New Jersey Statutes. It also was pointed out that the bill requires notification, but not necessarily approval or consent and could put the physician in the position of acting against the wishes of the patient or her family.

3. AMA Model State Legislation ...

Approved a recommendation that a matter concerning the AMA proposed legislation providing for an automatic termination date for the State Health Planning Law and MSNJ's position that Health Planning Laws should be repealed [in which case a termination date would be unnecessary] be considered at the next joint meeting of the Executive Committee of the Medical Society of New Jersey and the New Jersey Hospital Association.

4. Current State Legislation ... Approved the recommended positions on the following bills of medical interest:

S-1293 Feldman—Licensing of Speech Therapists and Audiologists

Creates a direct licensing system within the Division of Consumer Affairs for speech therapists and audiologists. Continuing education is mandated. The individuals so licensed would function independently. Physicians and their employees are exempt under the Act as long as the employee is not termed a "speech therapist or audiologist." *ACTIVE OPPOSITION*, because while audiologists, by training and experience, are technically competent individuals, they are not qualified to make judgmental decisions or to engage in clinical diagnosis. Granting licensure to those individuals would be a disservice to the public and would, indeed, produce increased costs for those services which they currently provide.

S-3174 Skevin—Discrimination

Prohibits discrimination against cancer victims by redefining "handicapped" to include those with health impairments caused by the pathological condition of cancer. *ACTIVE OPPOSITION*, singling out cancer is discriminatory, superfluous, and self-defeating. Functional disabilities, due to cancer, as well as other diagnoses, already qualify under existing law.

S-3202 Russo—Personal Injury

Would preclude governmental agencies from attaching that portion of awards or settlements to infants for personal injuries which is attributable to making the child "whole." *NO ACTION*

S-3208 Laskin—Age of Majority

Restores 21 years of age as the statutory age of majority in New Jersey. *NO ACTION*

S-3211 Ewing—Emergency Rooms

Provides that when a general hospital closes, a neighboring general hospital shall be permitted to maintain and operate its emergency room without a certificate of need if there is no other general hospital emergency room in the community. *APPROVED*

S-3229 Ewing—Marriage Licenses

Requires females under 45 years of age who are applying for a marriage license to submit evidence of having taken an immunological response test to rubella. The physician shall inform the applicant of the medical significance of the results of the test. *APPROVED*

S-3235 Lipman—Hereditary Disorders

Establishes a hereditary disorders program in New Jersey in the State Department of Health. *ACTION DEFERRED*, pending further information from the American College of Obstetricians and Gynecologists, New Jersey Chapter American Academy of Pediatrics, Council on Public Health, and Committee on Maternal and Child Care.

S-3242 Orechio—Academic Certificates (Same as A-3415)

Provides technical amendments to the licensing statutes deleting citizenship requirements. Additionally, this bill would delete the necessity for a certificate from the Department of Education. The Director of the Division of Consumer Affairs would certify the academic credentials of applicants to the various boards. *APPROVED*

S-3255 Russo—Motor Vehicles

Provides that at the direction of the licensee the Division of Motor Vehicles shall stamp on his/her driver's license the word "diabetic." *APPROVED*

S-3261 Feldman—Professional Liability

Would require plaintiffs in medical malpractice suits to file an affidavit of a practicing physician indicating there is a reasonable probability that a deviation from accepted standards occurred. The affidavit is not required if the defendant failed to provide plaintiff with medical records on a timely basis. The affidavit is waived if there is not sufficient time to file within the Statute of Limitations. The judge, in his/her discretion may, on motion, grant a summary dismissal. *CONDITIONAL APPROVAL*, pending amendment of bill—line #13 change word "board licensure" to "specialty board certification." If bill amended, *Active Support*.

S-3315 Feldman—College of Medicine and Dentistry of New Jersey (Same as A-3525)

Changes the status of the College of Medicine and Dentistry of New Jersey to that of a university and grants it corporate and operational authority similar to Rutgers. *ACTIVE SUPPORT*

S-3342 Yates—Physicians

Stipulates that the failure of a physician to inform a breast cancer patient of alternate forms of treatment constitutes professional incompetence under the Medical Practice Act. *ACTIVE OPPOSITION*, because the authority to revoke a license predicated on this type of action is already within the judgment discretion of the State Board of Medical Examiners. Also, medical judgment should not be legislated.

A-3009 Weidel—Prescription Legend Drug

Provides that stramonium preparation is to be regulated as a prescription legend drug.

Makes the cultivation and production of stramonium illegal except for pharmaceutical producers. **NO ACTION**

A-3379 Dowd—Professional Liability

This bill would preclude children and their parents from asserting "wrongful birth" claims. **ACTIVE SUPPORT**

A-3415 Otowski—Academic Certificates (Same as S-3242)

Provides technical amendments to the licensing statutes deleting citizenship requirements. Additionally, this bill would delete the necessity for a certificate from the Department of Education. The Director of the Division of Consumer Affairs would certify the academic credentials of applicants to the various boards. **APPROVED**

A-3440 Matthews—Cardiopulmonary Resuscitation

Requires CPR training for students in grades 11 and 12. **CONDITIONAL APPROVAL**, pending the inclusion of periodic updating of the techniques of CPR.

A-3444 Herman—Human Leucocyte Antigen Testing

Would admit the Human Leucocyte Antigen Blood Test into evidence to establish the positive probability of parentage. **APPROVED**

A-3457 Karcher—Contact Lenses and Eyeglasses

Prohibits the mail-order sale, dispensing, or distribution of refractive lenses to a retail buyer. **APPROVED**

A-3481 Villane—Blood Donors

Would override current regulations and allow persons over 65 years of age, in good health, to act as blood donors. **APPROVED**

A-3487 Hurley—Renal Dialysis

Would remove the moratorium on the establishment of additional renal dialysis programs. **APPROVED**

A-3525 Jackman—College of Medicine and Dentistry of New Jersey

Changes the status of the College of Medicine and Dentistry of New Jersey to that of a university and grants it corporate and operational authority similar to Rutgers. **ACTIVE SUPPORT**

A-3562 Brown—College of Medicine and Dentistry of New Jersey

The purpose of this bill is to place a licensed dentist on the board of trustees of the College of Medicine and Dentistry of New Jersey. **NO ACTION**

A-3583 Bornheimer—Alcoholism Treatment Services

This bill will amend the New Jersey Medical Assistance and Health Services Act (P.L. 1968 c.413) to mandate Medicaid coverage of alcoholism treatment services which have been prescribed by a physician. Currently, Medicaid only covers alcoholism treatment services which occur at a hospital. This bill would extend coverage to detoxification centers and approved residential treatment programs. **ACTION DEFERRED**, pending further information from the Ad Hoc Committee on Drug and Alcohol Abuse.

Medical Defense and Insurance . . . Approved the following recommendations from the Committee on Medical Defense and Insurance:

1. Group Term Life Insurance Plan:

That the Medical Society of New Jersey offer

its membership a Group Term Life Insurance Plan underwritten by the Hartford Life Insurance Company, as submitted by Donald F. Smith & Associates.

2. Dental Insurance Program:

That the Medical Society of New Jersey offer its membership a Dental Insurance Program underwritten by the New Jersey Dental Services Plan, Inc., as submitted by Donald F. Smith & Associates.

Proposed Rule on Same-Day Surgery . . .

Noted that a reply from the State Board of Medical Examiners advises that it concurs with MSNJ's position [objection to the proposed amendment to NJAC 10:52-1.3 and 10:53-1.3] concerning same-day surgery for Medicaid patients on the basis that the proposal was published with a "no public hearing" stipulation, that the medical profession was not consulted in the promulgation of the list of surgical procedures, that mandating certain surgical procedures to be performed in an outpatient setting within the hospital or out-of-hospital setting would not serve the best interests of all patients and that the option for same-day surgery should be at the discretion of the attending surgeon. The Division of Medical Assistance and Health Services is conducting a further analysis of the proposal along with a more realistic list of same-day surgery procedures.

Program To Increase AMA Membership

. . . Noted that in response to MSNJ's correspondence to presidents of hospital medical staffs suggesting that MSNJ Board of Trustees' members or members of the AMA Delegation address their quarterly meetings on the advantages of membership in the AMA, 36 hospitals have been assigned speakers, six are pending, one requested information, seven gave negative responses and there was no reply from 68.

Excessive Fee Committees . . .

Requested clarification from the State Board of Medical Examiners on the State Board's North and South Jersey committees on excessive fees and their referral of cases to county judicial committees.

Laboratory Disclosure Act . . .

Directed that the following information be forwarded to Dr. Charles Harris in response to a communication objecting to NJSA 45:1-10, which he believes discriminates against the medical profession:

According to the statute, it is unlawful for any person licensed in the State to practice

medicine or surgery, dentistry, osteopathy, podiatry or chiropractic to agree with any clinical, bioanalytical or hospital laboratory to make payments to such laboratory for individual tests, combination of tests or test series for patients unless such person discloses on the bills to patients or third party payers the name and address of such laboratory and the net amount or amounts paid or to be paid to such laboratory for individual tests, combination of tests or test series.

Common law related to professions has taken the posture that the practice of a profession is the rendering of a service and even though the professional happens to provide a particular item as part of the service, the individual is not really a retail merchant and cannot mark up on the goods provided. The statute does not prevent the physician from billing for the interpretation of the test or administrative processing. Attorneys are faced with a similar proposition, since rulings of the Supreme Court prevent them from marking up title insurance or searches they have ordered from others. They may charge for analysis of them but may not charge extra for the work of the title searchers or abstracters. It would be difficult to argue the case on the constitutional issue since the State Supreme Court philosophically has applied the concept to attorneys and it is unlikely that the Court would rule that the legislature did not have the right to apply the same concept to the medical profession.

Compendium of Rules and Regulations

. . . Each year regulations are adopted and decisions are rendered which alter the everyday practice of medicine and physicians are not always aware of these rulings. In view of this—

. . . Adopted a motion that the Society request the State Board of Medical Examiners to provide all licensed physicians with a compendium of its rules, regulations and policy decisions, along with annual supplements.

Cardiac Diagnostic Facilities and Cardiac Surgical Centers . . .

Directed that proposed amendments to the Standards and General Criteria for the Planning and Application for Designation of Cardiac Diagnostic Facilities and Cardiac Surgical Centers, proposed by the State Health Coordinating Council, be referred to the New Jersey Heart Association and the New Jersey Society of Thoracic Surgeons for review and comment.

Medicaid Procedure Code Manual . . .

Noted that the New Jersey Division of Medical Assistance and Health Services recently has mailed copies of its revised Medicaid Procedure Code Manual to New Jersey physicians who participate in the Medicaid program. A copy is on file at the Executive Offices.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President

We at CMDNJ have come to expect autumn to be our busiest season, with the students returning to classes and the institution gearing up to peak activity. This year, the fall months have been particularly eventful, however, since they were highlighted by several important advances for the College's programs.

In September, we welcomed 657 new students at our six schools, bringing the College-wide enrollment to nearly 2,000 undergraduates in medicine, dentistry, the life sciences and the allied health professions. The increase of some 200 students over last year's total registration is based partly on the phased expansion of the Newark schools which has been ongoing since the new campus was completed. But the total also reflects some important advances in our South and Central Jersey programs.

CMDNJ-Rutgers Medical School at Camden officially began its permanent operations this year with its first class of 30 students. Until now, the South Jersey program in allopathic medicine has consisted of clinical rotations at Cooper Medical Center, the program's core teaching hospital, by students enrolled at the CMDNJ-Rutgers Medical School, Piscataway. The new class, enrolled specifically for the South Jersey program, will take the first two years of basic science studies in Newark, alongside the students of CMDNJ-New Jersey Medical School. Their clinical education, the third and fourth years, will be conducted entirely in South Jersey at Cooper and other area health care facilities.

The CMDNJ-New Jersey School of Osteopathic Medicine, which also conducts its clinical programs in South Jersey, continued its development by entering a freshman class of 44 students. These students take their basic science classes at the Piscataway campus and their clinical studies at John F. Kennedy Memorial Hospital, Stratford, and other South Jersey facilities. Total enrollment in the school rose to 137 this year, about two-thirds of its projected maximum of 224.

Another significant step in the development of the South Jersey programs took place in October, with the groundbreaking for the Education and Research Complex, adjacent to Cooper Medical Center, Camden.

This \$9-million facility, projected for

completion by April 1, 1983, will serve as a base for both the allopathic and osteopathic clinical education programs. It will include classrooms, faculty and administrative offices, research laboratories and eventually, if funding can be identified, a health sciences library. When both programs reach full enrollment, by the middle of the decade, the complex will serve 208 students—112 third and fourth-year osteopathic students and 96 allopathic students.

CMDNJ's health care efforts in Camden also were enhanced this autumn with the dedication of the Bergen-Lanning Family Practice Center, a \$320,000 public health care facility, operated by the Camden County Department of Health in conjunction with CMDNJ under the College's Area Health Education Center (AHEC) program. The center, which will provide a full spectrum of primary care services to 27,000 residents of Camden's Lanning Square section, is the second of its kind. The first AHEC clinic, opened last year, serves 30,000 residents of East Camden.

A self-contained unit, equipped for a wide variety of screening and diagnostic tests, the center stresses continuity of care. Those registering at the facility gain a health care team of doctor, nurse and support personnel that serve the individual or family on an ongoing basis. Services provided are wide ranging and strongly emphasize prevention. In the children's program, for example, the service comprises immunization, well-baby visits, screening tests for lead poisoning and developmental disabilities and nutritional counseling in addition to care for acute and chronic illnesses.

The clinics comprise the health care component of the AHEC, which also sponsors 28 education programs emphasizing urban-oriented training for physicians, dentists, social workers, nutritionists and other allied health students and practitioners. The AHEC, which currently is funded through an \$8 million Federal grant, is a major element in CMDNJ's effort to correct South Jersey's serious health problems and critical shortage of health manpower.

In Central Jersey, this fall saw the long-awaited completion of the Teaching and Research Building adjacent to Middlesex General Hospital, New Brunswick. The \$12-million structure, which houses classrooms, laboratories, faculty offices and a library, has begun to serve as an academic center for the school's clinical programs. We are looking forward to a dedication ceremony in the spring, when Middlesex Gener-

al's entire multi-million dollar construction program will be completed.

The hospital, which now serves as core teaching facility to CMDNJ-Rutgers Medical School, has undertaken a construction and renovation program which includes a new ambulatory care center, an acute services facility, renovation and addition to the surgical suite, completion of new bed space in the Robert Wood Johnson Memorial Tower and a materials' distribution center. This will allow the hospital and the College to expand clinical education and health care programs, adding sophisticated tertiary care services, thus creating a major regional referral center for Central New Jersey.

MSNJ Auxilliary

Phyllis Romano
President

An enthusiastic audience attended the Auxiliary's Fall Seminar on October 5, 1981, at the Medical Society Headquarters, Lawrenceville. The theme was "Medicine in Society: Today and Tomorrow." The outstanding speakers were authorities in the fields of medical education, geriatrics, MSNJ's concerns, and the present and future directions in Medicine.

As the Auxiliary has accepted an expanded role with the Medical Society by participating on State and County Medical Society committees, particular knowledge is required. This seminar provided the exposure, interest and challenges, as well as the opportunity to discuss our concerns with the speakers during a question and answer period.

MSNJ President, Armando F. Goracci, M.D., spoke on "The March of Time"; Stanley S. Bergen, Jr., M.D., President of the College of Medicine and Dentistry of New Jersey, addressed the group on "Health Manpower Requirements in the 1980's"; Mrs. Anne Somers, Professor of the Department of Environmental and Community Medicine, Rutgers Medical School, presented "Geriatric Imperative: A New Challenge to the Medical Profession"; and Dr. Bruce C. Vladeck, Assistant Commissioner of Health of the State of New Jersey, informed us regarding the "Future of Long-Term Care." Chairman of the Seminar was Linda Hirsch (Mrs. Paul), and the moderator was Bernard A. Rineberg, M.D., member of

the Board of Trustees of the American Academy of Orthopaedic Surgeons, whose topic was "What is the Price of Government's Newer Plans to Contain Health Care Costs?"

Exhibits were displayed by State Committee Chairmen on Aging, AMA-ERF, Family, Children and Youth, International Health, Legislation, Medical Student Loan Fund, Membership, Mental Health, Safety and Emergency Care, including CPR, Volunteer Friendly Visitors and Widows and Orphans. The AMA-ERF Committee held a boutique sale. Luncheon was served in the Executive Dining Room.

Invitations to the Seminar were issued to MSNJ Chairmen of Councils and Committees, Presidents, Executive Directors, and Executive Secretaries of County Medical Societies, MSNJ Executive Staff, Academy of Medicine, Auxiliaries, as well as others.

Many questions were submitted by the audience to the panel. For lack of time, all could not be answered adequately. The aim of the seminar was to make the audience aware of the many problems in the various topics discussed, and to offer suggestions for eliminating a few of them. The evaluation of the seminar by those in attendance was — "educational—informative—interesting

—offer more seminars of this calibre."

The topic which seemed to generate the most interest was on aging and what assistance is being offered by the medical profession in overcoming some of the problems existing today.

We especially were pleased to have with us several presidents, executive directors and physicians from county medical societies, the vice-chairman of the MSNJ Advisory Committee to the Auxiliary, many MSNJ staff executives, and more than the usual number of Auxiliaries. We wish more could have had the opportunity to attend and be a part of this lively and exciting seminar.

216th Annual Meeting May 14-17, 1982

Resorts International, Atlantic City

Daily Schedule

Friday, May 14, 1982

- 3:30 p.m.—Board of Trustees' Meeting
- 5:00 p.m.—Delegate Registration

Saturday, May 15, 1982

- 7:30 a.m.—Delegate Registration
- 9:00 a.m.—House of Delegates
- 9:00 a.m.—Message Center, Exhibits, Auxiliary Arts and Hobbies Open
- 10:30 a.m.—House of Delegates (election)
- 12:00 noon—Golden Merit Award Ceremony followed by Reception for Award Recipients and their Families
- 1:00 p.m.—Reference Committee Meetings: "A", "B", "C", "D", "E", "F", "G", "H", Constitution and Bylaws
- 6:00 p.m.—JEMPAC Wine and Cheese Reception

Sunday, May 16, 1982

- 7:00 a.m.—JEMPAC Breakfast
- 8:00 a.m.—Registration Opens
- 9:00 a.m.—Message Center, Exhibits, Auxiliary Arts and Hobbies Open
- 9:00 a.m.—Scientific Sessions
 - Allergy; Chest Diseases; Cardiovascular Diseases; Emergency Medicine; Family Practice; Medicine; Orthopaedic Surgery; Pediatrics; Psychiatry; Surgery; Clinical Pathology; Oncology

11:30 a.m.—Luncheons

1:00 p.m.—Scientific Sessions

Spencer T. Snedecor Trauma Oration; Anesthesiology; Dermatology; Gastroenterology and Proctology; Clinical Pathology; Neurosurgery and Neurology; Nuclear Medicine, Radiology; Obstetrics and Gynecology, Urology; Ophthalmology; Otolaryngology—Head and Neck Surgery; Physical Medicine and Rehabilitation; Plastic and Reconstructive Surgery; Rheumatism

4:00 p.m.—Annual Meeting—Board of Governors of MIE

6:30 p.m.—Inaugural Reception

8:00 p.m.—Inaugural Dinner

Monday, May 17, 1982

- 6:30 a.m.—Essex County Breakfast Caucus
- 6:30 a.m.—Union County Breakfast Caucus
- 8:00 a.m.—Registration Opens
- 9:00 a.m.—Message Center, Exhibits, Auxiliary Arts and Hobbies Open
- 9:00 a.m.—House of Delegates (to consider Reference Committee reports)
- 12:00 noon—Message Center, Exhibits, Auxiliary Arts and Hobbies Close
- 12:00 p.m.—House of Delegates adjourns for lunch
- 1:30 p.m.—House of Delegates reconvenes
- 4:00 p.m.—House of Delegates adjourns
- 7:00 p.m.—Board of Trustees' Dinner-Meeting

**Alert and
functioning
in the
sunset
years**

Treat the symptoms in
the geriatric patient

**apathy
irritability
forgetfulness
confusion**

Cerebro-Nicin®

CAPSULES

A gentle cerebral stimulant
and vasodilator for the
geriatric patient

Each CEREBRO-NICIN® capsule
contains:

Pentylenetetrazole	..... 100 mg.
Nicotinic Acid	..... 100 mg.
Ascorbic Acid	..... 100 mg.
Thiamine HCL	..... 25 mg.
L-Glutamic Acid	..... 50 mg.
Niacinamide	..... 5 mg.
Riboflavin	..... 2 mg.
Pyridoxine HCL	..... 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057



Physicians Seeking Location in New Jersey

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ALLERGY/IMMUNOLOGY—Leonard Cohen, M.D., 7545 York Drive, Clayton, MO 63105. New York University 1977. Also general internal medicine. Board certified (IM). Board eligible. Multi-specialty group, partnership, solo, academic. Available July 1982.

ANESTHESIOLOGY—Hossain Esmaili, M.D., P.O. Box 1017, Franklin, VA 23851. Tabriz (Iran) 1971. Any type practice. Available.

CARDIOLOGY—Mark Lebenthal, M.D., 1164-4 Bibbs Road, Voorhees, NJ 08043. SUNY-Stonybrook 1977. Board eligible. Group or partnership—cardiology or cardiology/internal medicine. Available July 1982.

Stephen Rothbart, M.D., 1343 Amherst Avenue, Union, NJ 07083. CMDNJ 1977. Trained in all invasive and non-invasive techniques. Group, partnership, solo. Available July 1982.

Arkady B. Rapoport, M.D., 4121 Meadowbrook Lane, Minneapolis, MN 55426. Minnesota 1981. Also, general internal medicine. Board eligible (both IM and cardiology). Group, partnership, solo. Available July 1982.

Richard C. Redline, M.D., 26 Mt. Vernon Street, Apt. 4-F, Boston, MA 02108. Virginia 1977. Also, general internal medicine. Board certified (IM). All areas of cardiology including echocardiography, nuclear, catheterization. Group, partnership, solo. Available July 1982.

Naeem Anwar Khan, M.D., 64 Mayfair Drive, West Orange, NJ 07052. Khyber (Pakistan) 1973. Also, general internal medicine. Board certified (IM). Solo, group, partnership, hospital-based. Available July 1982.

EMERGENCY ROOM—Pramila M. Umaphathi, M.D., P.O. Box 1108, 27 Eagle Avenue, Apt. B, North Park, Wheeling, WV 26003. Madras (India) 1971. Also, family practice and obstetrics/gynecology. Group practice or hospital emergency room. Available.

FAMILY MEDICINE—Lisa Nierenberg, M.D., Somerset Family Practice, Rehill Avenue, Somerville, NJ 08876. Penn State 1979. Board eligible. Group (small). Available August 1982.

Pramila M. Umaphathi, M.D., P.O. Box 1108, 27 Eagle Avenue, Apt. B, North Park, Wheeling, WV 26003. Madras (India) 1971. Also, emergency room and obstetrics/gynecology. Group practice or hospital emergency room. Available.

Martin M. Keibel, M.D., 329 Water Street,

Hallowell, ME 04347. SUNY-Downstate
1977. Board certified. Group. Available
August 1982.

GASTROENTEROLOGY—Yong Wun
Chung, M.D., 3937 Lankenau Avenue,
Philadelphia, PA 19131. Chonnam (Korea)
1972. Also, general internal medicine.
Board certified (IM). Group, partnership,
solo. Available July 1982.

Philip Nagel, M.D., 8155 North Karlov,
Skokie, IL 60076. University of Pennsylvania
1974. Also, general internal medicine.
Board certified (IM). Consultative
gastroenterology—single or multi-specialty
group, clinic or hospital-based practice.
Available July 1982.

GENERAL MEDICINE—Biagio Scialpi,
M.D., 330 Park Hill Avenue, Yonkers, NY
10705. Bari (Italy) 1949. Group, solo, or
full-time position in industry or insurance.
Available.

HEMATOLOGY/ONCOLOGY—Michael
Willen, M.D., 164 Homestead Avenue,
Albany, NY 12203. New York Medical
1976. Also, general internal medicine.
Board certified (IM). Board eligible—
hematology/oncology. Group or partner-
ship. Available July 1982.

Douglas Faig, M.D., 3450 Wayne Avenue,
Apt. 23-D, Bronx, NY 10467. NYU 1976.
Also, general internal medicine and blood
banking. Board certified (IM). Board
eligible—hematology/oncology. Group,
partnership. Available July 1982.

INDUSTRIAL MEDICINE—Albert
Abraham, M.D., 11 Cromwell Drive, Con-
vent Station, NJ 07961. New York Univer-
sity. Board certified (IM). Medical direc-
torship (preferably in or near Morris Coun-
ty). Available.

INTERNAL MEDICINE—Herbert F. Rest,
M.D., 2 Belmont Avenue, Brattleboro, VT
03501. Hahnemann 1965. Group. Avail-
able.

Jay I. Lipoff, M.D., 214 East Spooner
Road, Milwaukee, WI 53217. NYU. Sub-
specialty, cardiology. Board certified.
Group or solo. Available January 1982.

Bakhti J. Sinor, M.D., VA Medical Center,
Dept. of Medicine, Northport, NY 11768.
Seth G.S. (India) 1973. Subspecialty,
hematology/oncology. Board certified
(hematology). Group, partnership in on-
cology/hematology. Available.

Jonathan R. Anolik, M.D., 6107
Breezewood Court, #203, Greenbelt, MD
20770. Loyola/Stritch 1977. Subspecialty,
endocrinology. Board certified. Group or
partnership. Available July 1982.

Jerome S. Fischer, M.D., 1400 South Joyce
Street, Arlington, Va 22202. Jefferson
1977. Subspecialty, endocrinology. Board
certified. Group or partnership. Available
July 1982.

T.M. Gupta, M.D., 8093-202 Valcour Ave-
nue, St. Louis, MO 63123. Osmania (In-
dia). Subspecialty, cardiology. Board
eligible. Solo, group, partnership (trained
in all aspects of invasive/non-invasive
cardiology). Available July 1982.

Harold S. Wilkes, M.D., 350 East 17th

A peripheral vasodilator

for treatment of
**leg cramps
cold feet
tinnitus
discomfort on
standing**

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

Gradual Release

LIPO-NICIN®/300 mg.

Each time-release capsule con-
tains:

Nicotinic Acid	..... 300 mg.
Ascorbic Acid	..... 150 mg.
Thiamine HCL (B-1)	..... 25 mg.
Riboflavin (B-2)	..... 2 mg.
Pyridoxine HCL (B-6)	..... 10 mg.

in a special base of prolonged
therapeutic effect.

DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release

LIPO-NICIN®/250 mg.

Each yellow tablet contains:

Nicotinic Acid	..... 250 mg.
Niacinamide	..... 75 mg.
Ascorbic Acid	..... 150 mg.
Thiamine HCL (B-1)	..... 25 mg.
Riboflavin (B-2)	..... 2 mg.
Pyridoxine HCL (B-6)	..... 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:

Nicotinic Acid	..... 100 mg.
Niacinamide	..... 75 mg.
Ascorbic Acid	..... 150 mg.
Thiamine HCL (B-1)	..... 25 mg.
Riboflavin (B-2)	..... 2 mg.
Pyridoxine HCL (B-6)	..... 10 mg.

DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasi-
dilatator in the symptoms of cold
feet, leg cramps, dizziness,
memory loss or tinnitus when
associated with impaired peri-
pheral circulation. Also provides
concomitant administration of
the listed vitamins. The warm
tingling flush which may follow
each dose of LIPO-NICIN® 100
mg. or 250 mg. is one of the
therapeutic effects that often
produce psychological benefits
to the patient.

Side Effects: Transient flushing
and feeling of warmth seldom re-
quire discontinuation of the drug.
Transient headache, itching and
tingling, skin rash, allergies and
gastric disturbance may occur.

Contraindications: Patients with
known idiosyncrasy to nicotinic
acid or other components of the
drug. Use with caution in preg-
nant patients and patients with
glaucoma, severe diabetes, im-
paired liver function, peptic ul-
cers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, California 90057



Street, Apt. 9-D, New York, NY 10003. New York Medical 1977. Subspecialty, cardiology. Board certified. Group, partnership. Available July 1982.

David Guttman, M.D., 353 East 17th Street, New York, NY 10003. New York University 1977. Subspecialty, gastroenterology. Board certified. Group, partnership, solo. Available July 1982.

Cuddalore P. Vasudevan, M.D., 14500 S. McNab Avenue, Apt. 404-C, Bellflower, CA 90706. Madras 1974. Subspecialty, pulmonary medicine. Board certified. Solo. Available July 1982.

James A. Scerbo, M.D., 3582 Green Brier Boulevard, Apt. 404-C, Ann Arbor, MI 48105. Columbia 1979. Partnership or group. Available July 1982.

Arvind M. Mehta, M.D., 672 General Scott Road, King of Prussia, PA 19406. Baroda (India) 1973. Subspecialty, cardiology (preferably noninvasive). Board eligible (both). Single or multi-specialty group. Available.

Randolph J. Swiller, M.D., 182-11 Henley Road, Jamaica Estates, NY 11432. Chicago 1972. Board eligible. Group or partnership. Available.

Harish N. Nagarsheth, M.D., 12 Marlboro Court, Maywood, NJ 07607. Seth (India) 1975. Subspecialty, cardiology. Board eligible. Hospital-based solo, partnership, group. Available July 1982.

NUCLEAR MEDICINE—Maria I. Straub, M.D., 254 Frances Street, Teaneck, NJ 07666. University of Budapest (Hungary) 1967. Special interest, diagnostic radiology. Board eligible. Available.

OBSTETRICS/GYNECOLOGY—Tsu Ming Chu, M.D., 269-19 80th Avenue, New Hyde Park, NY 11040. Kaohsiung Medical (Taiwan) 1972. Board eligible. Partnership, group, fellowship, full-time institute. Available.

Myles E. Dotto, M.D., 44 Lyndhurst Avenue, Providence, RI 02908. CMDNJ 1975. Board eligible. Group, partnership, solo. Available July 1982.

Gary K. Schneider, M.D., 145 East 27th Street, Apt. 5-B, New York, NY 10016. SUNY-Downstate 1978. Board eligible. Group, partnership, or academic. Available July 1982.

Pramilam M. Umaphathi, M.D., P.O. Box 1108, 27 Eagle Avenue, Apt. B, North Park, Wheeling, WV 26003. Madras (India) 1971. Also, emergency room or family practice. Group or hospital emergency room. Available.

Jay T. Genday, M.D., 245-20 Grand Central Parkway, Apt. 3-A, Bellerose, NY 11426. Georgetown 1978. Board eligible. Group, partnership, multi-specialty group. Available July 1982.

Paul Lam, M.D., 441 Valley Road, Melrose Park, PA 19126. Case Western 1978. Board eligible. Partnership, group, solo. Available July 1982.

Rodger A. Fraser, M.D., 109 Scott Street, Joliet, IL 60431. Howard 1974. Board eligible. Solo, group. Available June 1982.

OPHTHALMOLOGY—Charles D. Howard, MD., 2605 Stearns Hill Road, Waltham,

MA 02154. Guadalajara (Mexico) 1976. Special interest, corneal or external diseases. Solo, partnership, single-specialty group. Available July 1982.

Florence S. Lee, M.D., 676 Kent Avenue, Teaneck, NJ 07666. SUNY-Downstate 1976. Board certified. Partnership or group. Available.

ORTHOPEDICS—Cary Ian Skolnick, M.D., 2250 North Circle Drive, Ann Arbor, MI 48103. Creighton 1977. Partnership. Available July 1982.

OTOLARYNGOLOGY—Donald V. Wilson, M.D., 20 Lahiki Circle, Aiea, Hawaii 96701. Temple 1975. Board certified. Group, partnership, will consider solo. Available August 1982.

Arnold I. Charow, M.D., 6 Country Club Drive, Larchmont, NY 10538. Louisville 1966. Also, head and neck surgery. Board certified. Would cover ENT practice one day a week (Wed.). Available.

PATHOLOGY—Anna Kumar, M.D., 6223-B Newport Avenue, Norfolk, VA 23505. J.L.N. Medical (India) 1972. Board eligible (AP/CP). Group, solo, or partnership. Available.

Daniel Williams, Jr., M.D., 77 Rippowam Road, Apt. A, Stamford, CT 06902. Vanderbilt 1975. Special interest—clinical pathology and blood banking. Board certified. Any type practice. Available.

Parbati Basu, M.D., 3400 Henry Avenue, Philadelphia, PA 19129. N.R.S. (India) 1975. Board eligible. Any type practice. Available July 1982.

PEDIATRICS—Susheela Raghunathan, M.D., 9 Weston Place, East Brunswick, NJ 08816. India 1973. Board eligible. Group, institutional, clinic, emergency room, house staff or student health center. Available.

Bernard Samtoy, M.D., 4040 Marshall Avenue, Lorain, OH 44053. Montpelier (France) 1974. Subspecialty, pediatric nephrology. Board certified. Group or partnership. Available.

Richard Dicker, M.D., 23 Park Avenue, Caldwell, NJ 07006. Guadalajara (Mexico) 1978. Group or partnership. Available July 1982.

Prasanna G. Pradhan, M.D., 1319-D River Avenue, Lakewood, NJ 08701. Baroda (India) 1975. Board eligible. Group, partnership, or solo. Available.

PHYSIATRY—Lisa Bhansali, M.D., 49 Hamilton Lane South, Plainsboro, NJ 08536. LTM Medical College (India) 1972. Board eligible. Group, clinic or as staff. Available.

PHYSIATRY—Paul L. Maitheny, M.D., 99 Pawnee Road, Lakewood, NJ 08701. University of Graz (Austria) 1951. Board eligible. Available.

PULMONARY DISEASES—Paul M. Friedman, M.D., 1303 York Avenue, New York, NY 10021. SUNY-Downstate 1977. Board certified (IM). Group or partnership. Available July 1982.

Surinder K. Aneja, M.D., 90A Garden Village Drive, Apt #4, Cheektowaga, NY

14227. Punjab (India) 1974. Also, general internal medicine. Board certified (IM). Group or solo. Available July 1982.

Somnath N. Naik, M.S., 288 Bay 38 Street, Apt. 5-U, Brooklyn, NY 11214. Seth G.S. (India) 1976. Also, general internal medicine. Board certified (IM). Any type practice. Available July 1982.

REHABILITATION MEDICINE—Dinesh C. Shah, M.D., 79-16 67th Drive, Middle Village, NY 11379. Shah (India) 1969. General practice and rehabilitation medicine. Available on three months' notice.

RHEUMATOLOGY—Michael A. Friedman, M.D., 135 Loblolly Lane, Chapel Hill, NC 27514. Wisconsin. Board certified. Group, partnership, solo, hospital-based. Available.

Thomas A. Giangrasso, M.D., 3550 Jeanne Mance, Apt. 2402, Montreal, Quebec, Canada H2X 3P7. Medical College of PA 1975. Subspecialties, allergy/immunology. Board certified (also IM). Any type practice. Available.

SURGERY, GENERAL—S.R. Bajina, M.D., E1501, Park Towne Place, 2200 Benjamin Franklin Parkway, Philadelphia, PA 19130. Special interest—gastrointestinal endoscopy. Board certified. Solo, group, institutional-based. Available.

Rajendra M. Agarwal, M.D., 318 East 15th Street, New York, NY 10003. King George's (India) 1968. Solo, group, or partnership. Available.

P. Joshua Mammen, M.D., 404 West 51st Street, Apt. 2-B, New York, NY 10019. Trivandrum (India) 1970. Board eligible. Group, partnership, solo. Available.

B. Paulauskas, M.D., Route 1, Box 273-M, Lake Placid, FL 33852. Lithuania 1972. Special interest, vascular surgery. Board eligible. Group, partnership, solo. Available.

Kong Hua L. Go, M.D., 605 Louisiana Avenue, Apt. 17-A, Brooklyn, NY 11239. Far Eastern (Philippines) 1973. Board eligible. Any type practice. Available.

Job S. Kakkaseril, M.D., 3194 McGill Lane, Cincinnati, OH 45239. Pradesh (India) 1972. Board eligible. Group, solo, or partnership. Available.

M.S. Bose, M.D., Box 847, Mullens, WV 25882. Andhra (India) 1970. Board certified. Any type practice. Available.

Ahmed I. Khan, M.D., 5627 North 16th Street, Apt. H-8, Phoenix, AZ 85016. Dacca (Bangladesh) 1972. Also, peripheral vascular surgery. Any type practice. Available.

Robert C. Kahn, M.D., 2516 North 4th Street, Harrisburg, PA 17110. Pennsylvania 1977. Board eligible. Partnership or group. Available July 1982.

SURGERY, ORTHOPEDIC—Steven H. Fried, M.D., The Hospital for Special Surgery, 535 East 70th Street, New York, NY 10021. Rutgers 1975. Any type practice, plus part-time faculty position. Available.

Inder J. Singh, M.D., WCMC #1C Beachwood Hall, Valhalla, NY 10595.

K.G. Medical, Lucknow (India) 1968. Solo or partnership. Available.

Mark M. Kramer, M.D., 3450-12 Wayne Avenue, Bronx, NY 10467. Vanderbilt 1976. Board eligible. Private practice. Available.

SURGERY, PLASTIC—Vasdev S. Rai, M.D., 435 East 70th Street, Apt. 22-B, New York, NY 10021. Punjab (India) 1973. Board eligible. Solo, partnership, group. Available July 1982.

E. B. Mustafa, M.D., 825 Pontiac Avenue, Apt. 5102, Cranston, RI 02910. Alexandria (Egypt) 1973. Board certified (surgery). Board eligible (plastic surgery). Solo or association. Available.

SURGERY, VASCULAR—Pramod Batra, M.D., 600 East 18th Street, Apt. 2-C, Brooklyn, NY 11226. Patiala (India) 1969.

Board certified. Solo, group, associate. Available.

A. Ghosh, M.D., Apt. 135, 1645 East Thomas Road, Phoenix, AZ 85016. Prince of Wales (India) 1970. Board eligible. Solo, partnership, group. Available.

Ahmed I. Khan, M.D., 5627 North 16th Street, Apt. H-8, Phoenix, AZ 85016. Dacca (Bangladesh) 1972. Also, general surgery. Any type practice. Available.

UROLOGY—Talluri Balaji, M.D., 1926 West Harrison St., Apt. 916, Chicago, IL 60612. Osmania (India) 1973. Solo. Available July 1982.

Donald M. Bergner, M.D., 8300 Palmetto Street, Apt. 30, New Orleans, LA 70118. Bowman-Gray 1976. Board eligible. Group, partnership, multi-specialty. Available.

Jerome Patrick Parnell, M.D., 435 East 70th Street, Apt. 28-C, New York, NY 10021. SUNY-Downstate 1974. Board eligible. Partnership or group. Available.

Mahendra S. Shah, M.D., 62 Forsythia Lane, Paramus, NJ 07652. Baroda (India) 1968. Board certified. Group or partnership. Available.

Tahmoures Furoozi, M.D., 3646 Tuscula Avenue, Seaford, NY 11783. Esfahan University (Iran) 1966. Board eligible. Any type practice. Available.

Albert E. Kaufman, M.D., 2020 Forestdale Drive, Silver Spring, MD 20903. Ghent (Belgium) 1974. Board certified. Group, partnership. Available.

Dilip R. Patel, M.D., 483 Ocean Parkway, Apt. 4-B, Brooklyn, NY 11218. Baroda (India) 1973. Board eligible. Any type practice. Available.

LETTER TO THE JOURNAL

Insurance for Retired Physicians

October 22, 1981

Dear Sir:

We at the Medical Inter-Insurance Exchange of New Jersey were pleased to read Doctor Paul L. Grosner's recent letter regarding our coverage for retired physicians. This type of coverage is available to physicians who do not hold regular office hours and do not treat any new patients.

This coverage may be available to physicians who continue to practice occasionally or part-time at clinics or facilities where professional liability insurance is provided by the employer. Because employer-provided insurance usually protects the individual only for incidents occurring during the course of employment, our policy would exclude this activity and would provide coverage only for incidents that might occur outside of this employment. Good Samaritan encounters, prescribing for

friends and neighbors and unpaid consultations are situations in which this type of insurance could be applicable.

The current annual premium rate for the retired physicians classification ranges from \$473 to \$774, depending on the limits of liability desired. Any physician interested in this type coverage should contact our Underwriting Department at (609) 896-2404.

(signed) Pamela B. Tinsley
NJ State Medical Underwriters

LUPUS FACTS FOR YOUR PATIENTS

Lupus is the subject of a new Arthritis Foundation educational campaign.

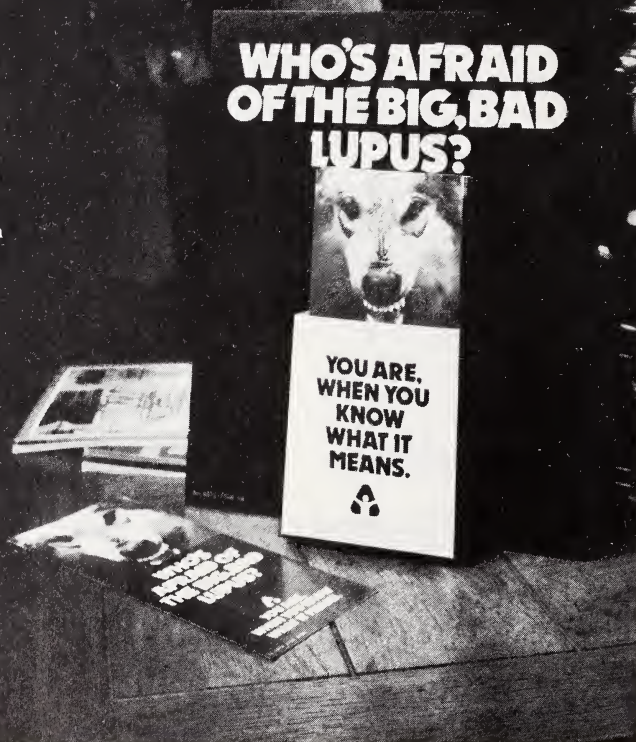
The campaign theme is: "WHO'S AFRAID OF THE BIG, BAD LUPUS?... YOU ARE WHEN YOU KNOW WHAT IT MEANS." Using a wolf as an attention getter, we will seek to inform the public about the LUPUS problem in the U.S., and the help that is available. Our literature will provide the warning signs for the disease and our consumer ads and broadcast materials will stress early diagnosis and proper medication and therapy, as the only defense.

We urge your participation in this effort. Our new fact-filled lupus brochure, written for the layman, covers such subjects as what is lupus, the diagnosis of lupus, who gets lupus, the pattern of lupus, signs and symptoms, a management/treatment program and prevention guidelines. Simply order the desired quantities from your local Arthritis Foundation Chapter office, or write "Lupus," Arthritis Foundation, 3400 Peachtree Road, NE, Atlanta, Georgia 30326.

With your help, the impact of this lupus educational campaign will be just what the doctor ordered.



ARTHRITIS
FOUNDATION



**WHO'S AFRAID
OF THE BIG, BAD
LUPUS?**

**YOU ARE,
WHEN YOU
KNOW
WHAT IT
MEANS.**



CME CALENDAR

This listing is compiled through the cooperation of the Committee on Medical Education of the Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

ANESTHESIOLOGY

Jan.

- 19 **Viral Hepatitis As It Relates to the Anesthesiologist**
7:45-8:45 p.m.—Ramada Inn, Clark
(*NJ State Society of Anesthesiologists and AMNJ*)

Feb.

- 6 **Clinical Anesthesia 1982**
8 a.m.-4:30 p.m.—New Jersey Medical School, Newark
(*CMDNJ and AMNJ*)

CARDIOLOGY

Jan.

- 13 **Risk Factors in Heart Disease**
27 **Is Atherosclerosis Reversible?**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)

Feb.

- 2 **Pre-Hospital Coronary Care**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
5 **Ventricular Tachyarrhythmias Related to Sudden Cardiac Death**
8:30-9:30 a.m.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)
17 **Cardiac Rehabilitation**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)

MEDICINE (includes Family, Internal, General Medicine and Dermatology)

Jan.

- 5 **Thyroid Diseases**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
6 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
6 **Immunology (Clinical)**
11:30 a.m.—Columbus Hospital Newark
(*AMNJ*)
6 **Proper Use of Endoscopy**
1 p.m.—Christ Hospital, Jersey City
(*AMNJ*)
6 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section of AMNJ*)
6 **Special Problems in Hypertension**
13 **Risk Factors in Heart Disease**
20 **Advances in Nutrition**
27 **Is Atherosclerosis Reversible?**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
6 **Endocrine Conferences**
13 3:30-5 p.m.—Rotates between Newark
20 Beth Israel Medical Center, College Hospital, Newark and VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
7 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(*Endocrinology Section of AMNJ*)
8 **Medical Grand Rounds**
11:30 a.m.—College Hospital, Newark
(*Endocrinology Section of AMNJ*)
8 **Workup of the Patient with F.U.O.**
12 noon—St. Mary's Hospital, Orange
(*AMNJ*)
8 **Proper Use of Antibiotics**
22 **Colitis: Extra Colonic Manifestations**
12 noon—Freehold Area Hospital
(*AMNJ*)
8 **Topic to be announced**
15 **Infectious Arthritis**
22 **Medical Mortality Conference**
29 **Cushing Syndrome**
8:30-9:30 a.m.—United Hospitals Medical Center, Newark
(*United Hospitals Medical Center*)
8 **Viral Hepatitis**
22 **Acute Respiratory Failure**
9-10 a.m.—Helene Fuld Medical Center, Trenton
(*Helene Fuld Medical Center*)
13 **Inflammatory Bowel Disease**
9:30-11:30 a.m.—Dover General Hospital
(*Dover General Hospital and Medical Center and AMNJ*)
14 **Endocrine Aspects of Aging**
21 **Endocrine Aspects II**
4-6 p.m.—Institute for Medical Research, Copewood St., Camden
(*Institute for Medical Research and AMNJ*)
15 **Renal Conferences in Nephrology**
4-5 p.m.—College Hospital, Newark
(*Nephrology Society of NJ and AMNJ*)
18 **Adrenal Dysfunction**
12:30-1:30 p.m.—West Hudson Hospital, Kearny
(*West Hudson Hospital and AMNJ*)
19 **CPR**
11 a.m.—Greystone Park Psychiatric Hospital
(*AMNJ*)
19 **Drug-Induced Liver Disease**
12 noon-1 p.m.—St. Mary's Hospital, Orange
(*AMNJ*)

- 19 **Hemodialysis-Associated Hypoxemia**
4-5 p.m.—Middlesex General Hospital, New Brunswick
(*CMDNJ and AMNJ*)
20 **Workup of a Case of Anemia**
1-2:30 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
20 **Rutgers Dermatological Conference**
6-9 p.m.—Ruigers Community Health Plan, 57 U.S. Highway 1, New Brunswick
(*Rutgers Medical School and AMNJ*)
21 **Hypertension—Simpler Diagnosis, Newer Management Methods**
5-6:30 p.m.—Somerset Medical Center, Somerville
(*Somerset Medical Center and AMNJ*)
26 **Functional Abnormalities of Chronic Lymphocytic Leukemia Lymphocytes**
7-9 p.m.—Coachman Inn, Jackson Dr., Cranford
(*NJ Blood Club and AMNJ*)
28 **Case Presentations**
8-10 p.m.—St. Barnabas Medical Center, Livingston
(*NJ Society for Gastrointestinal Endoscopy, Somerset Medical Center and AMNJ*)

Feb.

- 3 **Pathophysiology and Clinical Management of Bleeding Disorders**
9:30-11:30 a.m.—Dover General Hospital
(*Dover General Hospital and AMNJ*)
3 **Medical Grand Rounds**
11:30 a.m.—VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
3 **Dinner Meeting**
6-9:30 p.m.—Holiday Inn, East Orange
(*Endocrinology Section of AMNJ*)
3 **Topic to be announced**
6:30 p.m.—The Manor, West Orange
(*Urology Section of AMNJ*)
3 **Chronic Diarrhea**
17 **Diabetic Retinopathy**
1-2:30 p.m.—Christ Hospital, Jersey City
(*Christ Hospital and AMNJ*)
3 **Infection with Mycobacterium Tuberculosis and other Mycobacterium**
10 **Tumor Immunity and Immunotherapy**
17 **Cardiac Rehabilitation**
9-11 a.m.—Roosevelt Hospital, Menlo Park
(*Middlesex General Hospital and AMNJ*)
3 **Endocrine Conference**
10 3:30-5 p.m.—Rotates between Newark
17 Beth Israel Medical Center, College Hospital, Newark and VA Medical Center, East Orange
(*Endocrinology Section of AMNJ*)
4 **Medical Grand Rounds**
9:30 a.m.—Newark Beth Israel Medical Center
(*Endocrinology Section of AMNJ*)



LIKOFF CARDIOVASCULAR INSTITUTE
of Hahnemann Medical College & Hospital

CARDIOLOGY UPDATE . . .

is designed for the Internist/Cardiologist, which provides an intensive survey of the current status of Clinical Cardiology . . .

**Wednesday,
January 6, 1982**

*20 Minute Lectures—Questions
and Answers (10 minutes)*

MODERATOR: Bernard L. Segal, M.D.

Course Title: DERMATOLOGY AND INTERNAL
MEDICINE, New Advances in
Diagnosis and Management

Course Dates: February 12-14, 1982

Course Site: The Homestead, Hot Springs, Virginia

Sponsor: Medical College of Virginia

Guest Lecturer: Thomas B. Fitzpatrick, M.D., Ph.D.
Harvard Medical School

Fee: \$200.00

Credit: 13½ AMA Category 1 Credit Hours

Contact: Kathy E. Johnson, Box 48, MCV Sta-
tion, Richmond, VA 23298 (804)
786-0494

**DIAGNOSIS AND MANAGEMENT OF HYPER-
TROPHIC CARDIOMYOPATHY: CASE PRESENTA-
TION**

Morris N. Kotler, M.D.

**AN UPDATE ON PERCUTANEOUS TRANS-
LUMINAL CORONARY ANGIOPLASTY**

Demetrios Kimbiris, M.D.

NEW DEVELOPMENTS IN CARDIAC PACING

Leonard N. Horowitz, M.D.

**VALVE REPLACEMENT: MECHANICAL OR
BIOLOGICAL**

Eldred Mundth, M.D.

CASE PRESENTATION: DISCUSSION

Edward Catherwood, M.D.

3:00 PM—2nd floor New College Building,
Hahnemann
Medical College and Hospital

**• NO REGISTRATION FEE • NO ADVANCE
REGISTRATION REQUIRED • CME
CATEGORY 1 CREDITS CERTIFIED • WINE &
CHEESE SERVED AT 5:30 P.M. •**

GENERAL SURGERY

Jan.

- 6 **Breast Cancer**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)
- 26 **Surgical Management of Pressure Sores**
8-10 p.m.—Englewood Club, Englewood
(Englewood Surgical Society, Englewood
Hospital and AMNJ)

Feb.

- 24 **Gallbladder and Common Duct Disease**
1-2:30 p.m.—Christ Hospital, Jersey
City
(Christ Hospital and AMNJ)

**SURGICAL SPECIALTIES (includes ENT,
Neurosurgery, Ophthalmology, Orthopedic,
Plastics, and Vascular Surgery)**

Jan.

- 18 **Major Hepatic Resection**
7:45-9 a.m.—Newark Beth Israel

Medical Center
(Newark Beth Israel Medical Center and
AMNJ)

- 26 **Plastic Surgery-Reconstructive/Cosmetic**
8 p.m.—Warren Hospital, Phillipsburg
(AMNJ)

Feb.

- 3 **Vascular Surgery**
10:30 a.m.—St. Mary's Hospital, Passaic
(AMNJ)
- 16 **Osteoporotic Syndromes**
12 noon—St. Mary's Hospital, Orange
(AMNJ)
- 17 **Dinner Meeting**
6:30-10:30 p.m.—The Manor, West
Orange
(NJ Society of Colon and Rectal
Surgeons)
- 18 **Intramedullary Spinal Cord Tumors**
4-5:30 p.m.—College Hospital, Newark
(CMDNJ and AMNJ)

19 Pediatric Surgery

7:45 a.m.—Freehold Area Hospital
(AMNJ)

- 23 **Orthopedic Surgery Update**
8-10 p.m.—Englewood Club, 115 E.
Palisade Ave., Englewood
(Englewood Surgical Society, Englewood
Hospital and AMNJ)

MISCELLANEOUS

Jan.

- 13 **DRG and You**
1-2:30 p.m.—Christ Hospital, Jersey
City
(Christ Hospital and AMNJ)

Feb.

- 2 **Malpractice**
8 p.m.—Burdette Tomlin Memorial
Hospital, Cape May Court House
(AMNJ)

OBITUARIES

Dr. Leo J. Barone

Leo J. Barone, M.D., chief of the section on neurology and psychiatry at the Veterans Administration Medical Center in East Orange, died on October 2. A native of New Jersey, born in 1910, Dr. Barone earned his medical degree from the University of Naples (Italy) in 1934 and pursued a career in neuro-psychiatry. In addition to his work at the VA Hospital, he served as consultant at Chilton Memorial Hospital, Pompton Plains and St. James Hospital in Newark. During World War II, Dr. Barone served with the medical corps of the United States Army.

Dr. Dale E. Beverly

At the grand age of 87, Dale Ellis Beverly, M.D., a member of our Passaic County component, died on September 28 at Garden State Health Center after a long illness. A native of Providence, Rhode Island, Dr. Beverly earned his medical degree from Rush Medical College in 1927 and pursued a career in pediatrics. He established a private prac-

tice in Chicago and remained there until coming to Paterson and in 1965 where he accepted an appointment with the board of health of that city. He was certified by the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics. In 1977 Dr. Beverly was a recipient of MSNJ's Golden Merit Award indicating 50 years as a physician.

Dr. Mark E. Branon

On October 9, Mark E. Branon, M.D., a member of our Bergen County component, died at Muhlenberg Hospital, Plainfield, after a short illness. A native of Fairfield, Vermont, born in 1905, Dr. Branon earned his medical degree from the University of Vermont College of Medicine, class of 1933, and came to Rutherford to establish a practice in general medicine. He held staff appointments at Passaic General Hospital and St. Mary's Hospital in Passaic, serving also as president of the medical staff at the latter. He had retired in 1975

and was living in Watchung at the time of his death. During World War II, Dr. Branon served with the medical department of the AUS.

Dr. George J. Brick

At the grand age of 93, George J. Brick, M.D., a member of our Hudson County component and formerly chief of staff at St. Francis Community Health Center in Jersey City, died on October 3 at Valley Hospital, Ridgewood. Born in New Jersey, Dr. Brick was graduated from the Georgetown University Medical School in 1911 and returned to New Jersey to establish a general practice in Jersey City, which he maintained for 55 years, retiring in 1973. In addition to his private practice, Dr. Brick served at Ellis Island and was affiliated with St. Joseph's Home for the Blind in Jersey City. He also was a physician and surgeon for the Pennsylvania Railroad. Dr. Brick was a 1961 recipient of MSNJ's Golden Merit Award, indicating fifty years as a physician.

Dr. Lyman Burnham

One of Bergen County's senior members, Lyman Burnham, M.D., of Englewood, died on October 3 at his home. Born in Brooklyn, New York, Dr. Burnham received his medical degree at Cornell University Medical School in 1926 and established a practice in obstetrics and gynecology. He was board certified in his chosen field and had been on the staff at Englewood Hospital in the department of gynecology. Dr. Burnham received MSNJ's Golden Merit Award in 1926 in recognition of his 50 years of medical practice. He was 79 years old at the time of his death.

Dr. Percy L. Smith

One of Trenton's well-known obstetricians, Percy L. Smith, M.D., died on

October 12, after a long illness. Born in 1905, Dr. Smith was graduated from the University of Pennsylvania College of Medicine, class of 1933, and pursued graduate training in obstetrics and gynecology at that same institution before establishing a practice in Trenton. He was board certified in his specialty and a Fellow of the American College of Obstetricians and Gynecologists, and had been chief of the department of obstetrics and gynecology at the Mercer Medical Center in Trenton. Dr. Smith was active in civic affairs and had been medical adviser and medical director of Planned Parenthood in Trenton and was on the advisory board for the Children's Home Society of New Jersey. During World War II, he served with the medical department of the AUS.

Dr. Robert R. White

Notice just has been received of the death on September 9th of Robert R. White, M.D., a member of the Essex County Medical Society. Born in Macon, Georgia, Dr. White earned his medical degree from Harvard Medical School, class of 1924, and took graduate training in obstetrics and gynecology at Boston City Hospital and Boston Lying in Hospital. He had practiced in East Orange until retirement to Martha's Vineyard in 1976. Dr. White was a Fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists and had been on the staff at the Hospital Center at Orange. In 1974, he was a recipient of MSNJ's Golden Merit Award, indicating fifty years as a physician. Dr. White was 85 years old at the time of his death.

BOOK REVIEW

The Physicians' Drug Manual

Rubin Bressler, Morton D. Bogdonoff and Genell J. Subak-Sharpe, Editors. Biomedical Information Corporation. New York, Doubleday, 1981. Pp. 1213. (\$17.95; \$19.95—thumb indexed)

This volume is an adaptation of *The Physician's Compendium of Drug Therapy*. Specifically, the original version has been expanded to make it useful for the laity as a home health reference contain-

ing authoritative, illustrated discussions of disease states, a medical glossary and comprehensive information on 95 percent of all medications prescribed by primary care physicians, plus the most frequently prescribed nonprescription drugs as of January 1981.

Information on drugs, the aspect of the book of most use to physicians, is presented in a concise, tabular format, covering much the same ground as the product information in the *Physicians' Desk Reference (PDR)*. Some details of

pharmacology and toxicology are deleted, but information concerning drug interactions and alterations of laboratory values are added in many instances.

It is this reviewer's opinion that the amount of drug information presented in this compendium is excessive for most patients and, for this reason, the book is not one to be recommended generally to the laity. Physicians should, however, be aware of its existence as a popular source of reliable health-related data and advice. Hyman W. Fisher, M.D.

Acknowledgments

The Journal acknowledges the contribution of the members of the Editorial Board (whose names are listed on the title page of each issue) for their assistance in evaluating scientific manuscripts during the year past, and wishes to thank the following, whose reviews of books sent to *The Journal* were published during 1981 (Volume 78).

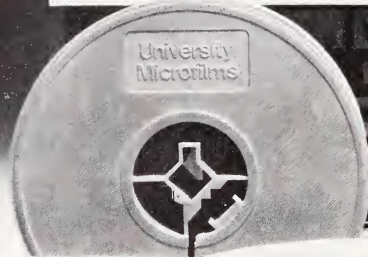
Jerome Abrams, M.D.
Francis P. Chinard, M.D.
Richard J. Cross, M.D.
Stanley S. Fieber, M.D.
Robert P. Haberkern, M.D.
Ellsworth C. Havens
Leonard Hollander, M.D.
Jack R. Karel, M.D.
Avrum L. Katcher, M.D.

Arthur S. Kern, M.D.
Bernard J. Koven, M.D.
Hugh F. Luddecke, M.D.
Robert M. MacMillan, M.D.
John S. Madara, M.D.
Geobel A. Marin, M.D.
A. Johan Noordsij, M.D.
Daniel J. O'Regan, M.D.
Irwin W. Pollack, M.D.

Norman Riegel, M.D.
Morris H. Saffron, M.D.
Rudolf E. Schwaeble, M.D.
Edith T. Shapiro, M.D.
Mark M. Singer, M.D.
Frank C. Snipe, M.D.
A. Arthur Sugerman, M.D.
Frank C. Vanore, M.D.

This publication is available in microform.

UNIVERSITY MICROFILMS INTERNATIONAL



University Microfilms International

Please send additional information for _____
(name of publication)

Name _____

Institution _____

Street _____

City _____

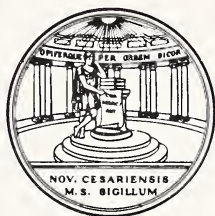
State _____ Zip _____

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London WIN 7RA
England

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Index



1981

Society established July 23, 1766
Journal founded September 1, 1904

VOLUME 78

JANUARY TO DECEMBER, 1981

Published monthly under direction of the
COMMITTEE ON PUBLICATION
PAUL J. HIRSCH, M.D. *Chairman*
DIRCK L. BRENDLINGER, M.D.
JULIO DEL CASTILLO, M.D.

ARTHUR KROSINICK, M.D., *Editor*
MARJORIE D. TREPTOW, *Managing Editor*

Editorial Office
2 PRINCESS ROAD
LAWRENCEVILLE, N.J. 08648

TABLE OF PAGES

January	1 to 76
February	77 to 156
March	157 to 248
April	249 to 332
May	333 to 412
June	413 to 488

December	859 to 942
----------------	------------

A

Abraham, Albert, M.D.	le622
ACCP Fellows	140
Acetaminophen Overdose—Miller	*523
ACP Fellows	549
Adolescent Breast Disease—Bloomenstein	le141
Agarwal, Shashi K., M.D., Albuquerque, NM	c125
Agoraphobia: The "What If" Syndrome—Fier	*286
Alessi, Alfred A., M.D.	e263
Alewitz, Sam, Clementon	mh381
Alfandre, Howard J.	†704
Affuso, Philip S., M.D., Teaneck	*677
Alpert, Joseph, M.D., Newark	e87
Alternate Delegates, Seating of—Resolution #13	614
Altman, Ronald, M.D., Trenton	*591
AMA Department of Negotiations—Resolution #38E	615
, Mandatory Membership in the—Resolution #20	614
National Awards Program (Dr. George)	310
Video Clinic	229
Amenorrhea: The Modern Office Evaluation—Pelosi	*195
Aneurysm of the Pancraticoduodenal Artery—Mariano; Greco	*191
Aneurysms: Subclavian and Axillary—Israel; Sussman; Ibrahim; Dardik; Kahn; Dardik	*173
Angioplasty, Transluminal, in Treatment of Lower Extremity Arterial Occlusive Disease—Rodriguez; Hardesty	*93
, Transluminal, of the Peripheral Vessels—Cholankeril; Rowen; Gural	*99
Annual Meeting, Committee on	58
Meeting (1981)—Daily Schedule	308
Meeting (1982)	692
Meeting (1982)—Daily Schedule	774, 851, 919
Reports, Guidelines for	692
Anson, Leon J., M.D.	le321
Antidepressants, Use of, from Conception to Delivery—Goldfarb; Keating	*357
Anxiety and Action—Todd	e804
Aortic Dissection: Rare Cause of Superior Vena Cava Syndrome—Riley; Liu; Saxanoff	*187
Apolito, Arnaldo, M.D., Montclair	cm603
Apter, Jeffrey T., M.D., Belle Mead	*679
Arterial Occlusive Disease of Lower Extremity—Treatment with Transluminal Angioplasty—Rodriguez; Hardesty	*93
Assembly Bill 2135	396
Bill 3002	396
Auxiliary, Advisory Committee to	313

B

Baker, Augustus L., Jr., M.D., Dover	*467
Balakian, Gerard	†558
Ballgame, A Whole New—Guarini	*215
Baran, Robert J., M.D.	le621
Barone, Leo J.	†928

July	489 to 564
July Transactions	Tr 1 to Tr 72
August	565 to 632
September	633 to 710
October	711 to 790
November	791 to 858

Barry, R. Grant	†151
Basic Biomechanics of the Skeletal System	br328
Bastidas, Jefferson, M.D., Livingston	*447
Battalino, Charles B.	†326
Beaugard, Edouard P., M.D., Teaneck	*677
Beauregard, William L., M.D., Camden	cm907
Becker, Stanley, M.D., Freehold	*41
Bedell, David W., R.Ph.	le553
Bergen, Marshall	†326
Bernstein, Arthur, M.D.	el70, le401
Berry, Silvia, M., M.Sc., East Orange	*26
Bertland, Alexander U.	†326
Besson, Franklin J., M.D.	†852
Beverly, Dale E.	†928
Bew, Richard C.	†626
Bierenbaum, Marvin L., M.D., Montclair	*439
Bilateral Synchronous Primary Lung Cancer—Goldshlack; Safirstein	*751
Bile Peritonitis after Routine T-Tube Removal—Rosenberg; Konigsberg; Finkelstein	*532
Biliary Tract Obstruction, Nonsurgical Evaluation and Management of Malignant—Loigman; Mattern; Healey; Hayes	*883
Binder, Joseph	†151
Biofeedback—Issues in Treatment Assessment	br485
Biosynthetic Human Insulin	e261
Bird, Mrs. Lewis (Juanita)	le401
Biunno, Anthony J.	†626
Blackburn, Robert T., Ph.D., Ann Arbor, MI	*443
Blanchet, Renaud	†407
Bloomenstein, Richard B., M.D.	le141
Blue Cross Coverage for Rehabilitation Treatment—Resolution #3	615
Shield, MSNJ Executive Committee Meeting with	478
Bone Scan, The, in Blastic Variant of Multiple Myeloma—Zeiger; Kuroda	*451
Book Reviews	72, 152, 242, 327, 408, 485, 627, 854, 000
Boorjian, Peter C., M.D., Montclair	*39
Bowers, John Z., M.D., New York	mh539
Bradley, Honorable Bill	le141
Branon, Mark E.	†928
Brick, George J.	†928
Brill, Robert	†852
Bromberg, Jules H., M.D.	le846
Brozyna, Matthew J.	†626
Buchanan, Ralph M.L. (1907-1980)	†70, e88
Burbella, R., M.D., Newark	*374
Burn Out	br242
Burnham, Lyman	†928
Bygone Practice in North Africa—Moskowitz	le846
Practice in North Africa—Bromberg	le846
Practice in North African Country—Calo	mh606
Byrne, Richard J., M.D.	le321

C

Calcium Pyrophosphate Deposition Disease: A Commonly Unrecognized Entity—Moss; Solomon	*369
Calderone, Joseph P., Jr., A.B., Jersey City	*519

Calo, Aldo A., M.D., Princeton	mh606
Campbell, Charles P.	*852
Cancer, Childhood—Ryan, Walters	*658
Mortality, Trends in—Comparison of Geographic Distribution in 1950-1969 and 1969-1975—Thind; Najem; Cohen; Levy; Louria	*527
Cantalupo, Thomas E.	*852
Carcinoma Arising Out of a Primary Acquired Cholesteatoma—Westerman; Sylvia; Tepper	*600
Cardiac Catheterization and Angiography	br242
Cardiopulmonary Resuscitation Program	223
Resuscitation Program for Industry	228
Cardiovascular Foreign Body: Discussion of Etiology and Nonoperative Retrieval—Cholankeril; Ketyer; Verzosa; Gural	*897
Carone, F.A., M.D., Chicago	*116
Carrier Foundation, The—Garber	sa535
Cash, Norman L.	*170
Cataldi-Betcher, Emma L., M.S.	le553
Cataract Surgery, Elective, Preadmission Evaluation and—Maltzman; Cinotti; Calderone	*519
Caution: I Brake for Unicorns	e17
Cerebral Concussion—Chodosh	le320
Thrombosis, Platelet Aggregation and Viral Infection—Geller; Stier; Somol; Watson; Naso; Bierenbaum; Fleischman	*439
Chemical Fire at Toxic Waste Disposal Plant: Epidemiologic Study of Exposure to Smoke and Fumes—Halperin; Landrigan; Altman; Iaci; Morse; Needham	*591
Child at Risk, The	br243
Childhood Cancer: Survival Statistics in a Pediatric Center—Ryan; Walters	*658
Chinard, Francis P., M.D., Newark	*296
Chirovsky, George, M.D., Livingston	*447
Chodosh, H. Louis	le320
Cholankeril, John V., M.D., Elizabeth	*99, *897
Cimetidine: Use, Abuse and Overuse—Marin	*595
Cinotti, Alfonse A., M.D., Jersey City	*519, *673
Clarke, Francis M., Sr.	*240
CMDNJ and Postgraduate Physician Training in New Jersey—Marshall	sa903
Notes	60, 136, 228, 315, 397, 482, 548, 616, 694, 770, 840, 918
Report to Board of Trustees	222, 394
CME Calendar	65, 145, 235, 323, 405, 483, 556, 623, 699, 777, 847, 925
Requirement, Mandatory	692
Coccia, S. Paul	*558
Coffee and Cancer	e343
Cohen, I., B.S., Newark	*527
Cole, Nathaniel B.	*407
Collins, Laurence M.	*326
Colombia Discovered—Lewis	le401
Committees and Councils (1981-1982)	686
Competition in Medicine—The New Strategy— Mintzer	e871
Coping with the Impending Doctor Glut—Louria ..	e503
Coriell, Lewis L., M.D.	le402
Cornell, Russell J., M.D.	le620
Cost Containment and Safety for Office Surgery— Bloomenstein; Mauro	cm213
County Representation at Board Meetings	394
Cowen, David L., M.A., Piscataway	*758
Crowley, Joseph W.	*484
Cryosurgery for Skin Cancer—Kuflik	*277

Cunningham, Charles	*407
Current Medical Diagnosis and Treatment, 1981 ..	br327
Patterns of Acute Renal Failure—Donatelli ..	*819
Surgical Diagnosis and Treatment	br706
Cystic Medical Necrosis of the Ascending Aorta— Spindell; Shah	*663

D

Danzis, Louis	*852
Dardik, Herbert, M.D., Englewood	*173
Irving, M.D., Englewood	*173
Davessar, Kanta, M.D., Freehold	*41
Davis, Stanton H.	*170
Dawson, William M.	*626
DeBiao, Cornelius V.	*484
Demos, Nicholas J., M.D., Jersey City	*105
DePace, Nicholas L., M.D., Philadelphia	*754
DESAD Project	617
Digestive Diseases, Developments in	br328
DiGiacomo, W.A., M.D.	*901
DiNicolantonio, V.J.	*240
DiSanto, Filippo	*626
Diuretic Therapy—Dodelson; Sherman; Gary; Eisinger	*748
DMSO Controversy—Coriell	le402
Controversy—A Congressional Perspective— Roe	*54, le402
Doctor Glut—Cohen	le775
Glut, Coping with the Impending—Louria	e503
Doctors' Case Against the Pill, The	br559
Dodelson, Robert, M.D., Piscataway	*119, *748
Donatelli, Anthony A., M.D., Plainfield	*819
Dornfeld, Richard, M.D.	*673
Double Tachycardias—Rothfeld	e48
DRG	e262
System	58
—What Your Patients are Reading	e577
Driving Aids, Assistive, for the Disabled— Reichenberger	*271
Drug Abuse, Theories on: Selected Contemporary Perspectives	br329
Scene, The Current—Russo	*889
Dual Fee System—Resolution #30	615
Dues Delinquent Members—Reinstatement Policy for	225
Exemption	479
Paying Methodology, New, for State and AMA Dues—Resolution #34	615
Duodenal Hematoma—Rothman	cn50
DuPree, Richard H.	*626
Duschock, Edward F.	*626

E

Echocardiographic Criteria, An Evaluation of, for Cardiac Tamponade—Weisse	*513
Eckhardt, Janet L.	*852
Editor's Desk, The	e343
Eisenstat, Theodore E., Plainfield	*887
Eisinger, Robert P., M.D., Piscataway	*748
Election of Officers by Mail Ballot	693
Elguezabal, Alberto, M.D., Philadelphia	*754
Endoscopy and Upper Gastrointestinal Tract Bleeding—Levinson; Kerner	*829

*—Original Article

†—Obituary

br—Book Review

c—The Electrocardiogram

cm—Commentary

cn—Clinical Note

e—Editorial

le—Letter

mh—Medical History

sa—Special Article

tr—Transactions

Equal Rights for Men and Women— Resolution #37	615
Ernst, B., C.P., Newark	*22
Ethnic Aspects of Boxing and the Ringside Physician—Williams	*654
Euthanasia: Where Are We? Where Are We Going?—Fish	*812
Eye Screening in New Jersey—Dornfeld; Jacobs; Cinotti	*673
Excessive Fee Regulation Proposed	225, 310, 394, 479
Extein, Irl, M.D., Summit	*731

F

Falcone, John G.	*852
Farabaugh, Robert E.	*783
Farmer, Wayne, M.D., Freehold	*41
Fellman, Damon M., M.D.	le845
Fernand, Robert, M.D., Newark	*22
Fernando, Nirmal K., M.D., New Brunswick	*119
Ferrand, Shelley Meriweather, M.H.S.A., Lawrenceville	sa457
Fessler, A. James	*151
Fessman, John W., III	*484
Fieber, Stanley, M.D., Livingston	*377
Fier, Morton, M.D., Hackensack	*286
Finance and Budget, Committee on— Recommendations	479
Finkelstein, Norman M., M.D., New Brunswick	*532
Fish, Marvin S., Newark	*812
Fisher, Samuel	*240
Five-Digit Procedure Coding—Resolution #18	615
Fletcher, H. Stephen, M.D., Livingston	*291
Fleischman, Alan I., Ph.D.	*439
Florio vs. Kean	e724
Food Allergy—Rosen	le232
Foreign Bodies of the Rectum—Garber; Rubin; Eisenstat	*887
Forline, John W.	*558
Fox, Thomas G., Ph.D., Piscataway	*443
Future of Medicine in the Eighties—Madara	e872
Medical-Legal Problems—Brennan; Smith	*463

G

Gadomski, Casimir	*240
Garbarini, John G.	*704
Garber, Harvey I., M.D., Baltimore	*887
Robert S., M.D., Belle Mead	sa535
Gardam, James E.D., M.D.	le554
Gartenberg, Gary, M.D., New Brunswick	*119
Gary, Nancy E., M.D., Piscataway	*748
Garzieri, Anthony R.	*783
Gastrointestinal Tract Bleeding, Endoscopy and Upper—Levinson; Kerner	*829
Gastroplasty, A New, for Reflux Esophagitis— Demos	*105
Geller, Martin, M.D., Elmhurst	*439
General Ophthalmology, 9th ed.	br152
George, James E., M.D., Woodbury	sa207
Giant Left Atrium with Massive Mural Thrombus in a Patient with Mitral Stenosis— DePace; Elguezabal; Kotler; Wagner	*754

Gilman, C. Malcolm B.	*852
GMENAC—From "Advisory to Regulatory"; Another Bureaucracy to Contend with—Malta	e88
Gold, Mark S., M.D., Summit	*731
Golden Merit Awards	475
Goldfarb, Charles, M.D., Staten Island, NY	*357
Goldshlack, Jack, D.O., Newark	*751
Goldstein, Morton H., M.D.	le553
Goldstone, Robert A., M.D.	le143
Gooch, Al, M.D.	le620
Good Idea, A: An Introduction to the Nutrition Foundation	br153
Goracci, Armando F., M.D., Woodbury	*435
Armando Frank, M.D., 189th President	e425
Gould, Lawrence, M.D., Lyons	*374
Graeter, F. Albert	*484
Greco, Ralph S., M.D., Piscataway	*32, *191
Greenleaf, Arthur	*484
Gregory, Margaret, M.D., Trenton	*36
Grosner, Paul L., M.D.	le775
Gruntzig's Plaque Pressing: "Verbum Sapienti"— Alpert	e87
Guarini, The Honorable Frank J., Washington, D.C.	*215
Gubernatorial Reception	915
Gural, Frank, R.T., Elizabeth	*99, *897
Gururaj, Vymutt, M.D., Lubbock, TX	*737

H

Halbeisen, William A.	*704
Hall, Winthrop H.	*558
Halperin, William, M.D., Cincinnati, OH	*591
Handbook of First Aid and Emergency Care	br72
Handicapped Physicians—Zondlo	le141
Hardesty, William H., M.D., Trenton	*93
Harris, Maurice N.	*626
Morris	*704
Harvey, Robert K.	*484
Hayes, Thomas H., R.T., Montclair	*883
Hayman, Irving	*627
Healey, Raymond F., M.D., Montclair	*883
Health Maintenance Organizations—Resolution #16	615
Systems Agencies—Resolution #5 (1980)	395
Systems Agencies—Resolution #9	615
Systems Agencies (HSAs)—Resolution #25	615
Hegeman, Runkle F.	*770
Help a Student and Help MSNJ	e425
Hemophilus Influenzae Infection, An Unusual Case of—Stitelman; Josephson	*530
Hermann, Henry L.	*240
Hiatt, Howard H., M.D.	le230
Hirsch, Paul J., M.D., Bridgewater	*585
Stuart A., M.D., Bridgewater	*585
HMO—Bernstein	le401
Experience, A Decade of	e645
Hobson, Jane Smith	*240
Robert W., II, M.D., Newark	*26
Hoffman, George A.	*484
Holt, Richard W., M.D., Washington, D.C.	*289
Holtzman, Michael	*704
"Hopefully" Will Disappear—I Hope!	e874
Hospital Book, The	br629
House Has Spoken, The	e501

1-76—Jan.
77-156—Feb.
157-248—Mar.
249-332—April

333-412—May
413-488—June
489-564—July
Tr1-Tr7—July
565-632—Aug.

633-710—Sept.
711-790—Oct.
791-858—Nov.
859-942—Dec.

Housing Application, Annual Meeting	47, 56, 110, 118, 127, 233
Hubach, M.F., Jr.	*558
Hubschmann, Otakar R., M.D., East Orange	*351
Hughes, Frank J.	*627
, Honorable William J.	1e142
Human Patient, The	br152
Hunt, Ezra Mundy—Physician, Writer, Humanitarian	mh381
Hypercalcemia in Pregnancy—Treatment with Oral Phosphates—Levy; Pierucci; Stroup	*113
Hyperprolactinemia, Diagnosis and Management: Part II—Kemmman; Jones	*743

I

Iaci, Alfred W., M.S., Trenton	*59
Ibrahim, Ibrahim M., M.D., Englewood	*173
Immunology, Basic and Clinical, 3rd ed.	br72
Immunotherapy: The Unfulfilled Promise—Greco	*32
Impaired Physicians, Help for	51, 143, 531, 613, 683, 764, 896
Inappropriate Prescription Drug Use	el69
Infant Feeding Practices by Ethno-Cultural Grouping—Russo; Patel; Laude; Rajkumar; Gururaj	*737
with Streptococcus Bovis Meningitis— Murillo; Titelbaum; Martinez	*598
Inflammatory Bowel Disease, 2nd ed.	br327
Bowel Disease, Mucosal Biopsy in Evaluation of—Rickert	*181
Insulin—The Old and the "New"—Krosnick	cm306
Integrated Medicine, vol. II of A Companion to the Life Sciences	br328
IRS Determination on Subordinated Loan Payments ..	58
Isen, Paul J.	*853
Iskowitz, Robert, M.D.	622
Israel, Michael, M.D., Englewood	*173

J

Jacobs, Glenn, M.D.	le620
Ivan H., M.D., Newark	*362, *673
Jamaica Needs Services, Medications and Supplies— Smith	le232
JEMPAC Rebuttal—Watson	le143
Reportorial	21, 91, 172, 267, 347, 429, 509, 653, 727, 806, 877
Support—Sibert	le142
Jennings, Robert E.	*240
Jones, J.R., M.D., Piscataway	*741, *743
Josephson, Benjamin, M.D., Summit	*530
Jurewicz, Stanley T.	*627
Juvenile Rheumatoid Arthritis—Solomon	*893

K

Kahn, Mark, M.D., Englewood	*173
Karopoulos, Alexander, S., M.D., Perth Amboy ...	*379
Katoos, Andrew S., Jr., Ph.D., Pearl River, NY	*26
Keating, Garrett, M.D., Plainfield	*357
Kemmman, E., M.D., Piscataway	*741, *743

Kerner, Michael B., M.D., Springfield	*829
Ketyer, Sidney, M.D., Elizabeth	*897
King, Edith E., New York	mh539
Louis, D., Ph.D., Piscataway	*758
Kissinger, Donald J., M.D., Teaneck	*677
Klein, Jonathan D., East Orange	477
Kler, Joseph H., M.D.,	mh121
Konigsberg, Stephen F., M.D., New Brunswick	*532
Kotler, Morris N., M.D., Philadelphia	*754
Kreitzer, Michael, M.D., Trenton	*36
Krivit, Lawrence R.	*627
Krosnick, Arthur, M.D.	cm306
Kuflik, Emanuel G., M.D., Lakewood	*277
Kuroda, Koson, M.D., Camden	*451
Kyphoscoliosis: Maternal Mortality in Pregnancies Complicated by—Kreitzer; Gregory	*36

L

Lamb, Richard R.	*484
Landrigan, Philip J., M.D., Cincinnati, OH	*591
Laude, Teresita A., M.D., Brooklyn, NY	*737
Law and Emergency Care	br242
Lawrence, David, M.D., Livingston	*447
Legal Services Plan	58, 310
Services Plan for Physicians, Comprehensive— Resolution #23	614
Legionnaire's Disease—Rhabdomyolysis With Acute Renal Failure—Gartenberg; Weinstein; Fernando; Dodelson; Ribat	*119
Legislation	311, 916
Letters for the Information of Our Readers	142, 402, 846
to <i>The Journal</i>	64, 141, 230, 320, 401, 553, 620, 775, 845, 923
Levinsohn, Sandor	*783
Levinson, Joel D., M.D., Springfield	*829
Levy, Howard A., M.D., Camden	*113
R., Newark	*527
Lifeline Program	691
System	879
Lifschultz, B.D., M.D., Chicago	*116
Lipoma of the True Pelvis—Chirovsky; Lawrence; Bastidas	*447
Lipson, Jeffrey	*240
Listeria Monocytogenes Meningitis in an Infant of a Habitual Aborter—Murillo; Titelbaum	*832
Liu, Roger T., M.D., Piscataway	*187
Loan Agreement—MSNJ Headquarters	58
Loigman, Barry I., M.D., Montclair	*883
Long Range Planning and Development	692
Loop Colostomy or Ileostomy with Immediate Application of Appliance, Creation of—Pello; Beauregard	cn907
Lordi, Nicholas G., Ph.D., Piscataway	*758
Louria, Donald B., M.D.	e503, *527
Ludwig, Shelly L., M.D., Piscataway	*453
Lumbar Spinal Stenosis, the Syndrome of, and Its Surgical Treatment—Hubschmann; Weisbrot	*351
Lung Cancer, Bilateral Synchronous Primary— Goldshlack; Safirstein	*751
"Lyme Disease," A Case of, Acquired in New Jersey—Ward	cn469
Lynch, Edward T.	*558

*—Original Article
†—Obituary
br—Book Review
c—The Electrocardiogram

cm—Commentary
cn—Clinical Note
e—Editorial

le—Letter
mh—Medical History
sa—Special Article
tr—Transactions

M

Mackes, Claude B.	†326
Madara, John S., M.D.	e872
Maggio, George A.	†558
Magnes, Max, M.D.	le64
Malpractice Insurance for Semiretired Physician— Grosner	le775
Insurance for Semiretired Physician— Tinsley	le923
Malta, Frank J., M.D.	e88
Maltzman, Barry A., M.D., Jersey City	*519
Management of Endocrine Disorders	br408
Mariano, Elpidio C., M.D., Piscataway	*191
Marin, Geobal A., M.D., Trenton	*595
Marshall, Carter, M.D., Newark	sa903
Marsters, Charles E., P.A., East Orange	*26
Martinez, Jaime, Newark	*598
Maternal Deaths in N.J.—1979—Thompson	*825
Mattern, Richard F., M.D., Montclair	*883
McIntyre, Russell L., Th.D., Piscataway	*809
Mearns, James B.	†627
Medicaid Regulations	691
Reimbursement	224, 311
Rule Proposals	548
Medical Aspects of School Sports	395
Care, High Cost of—Somjen	le554
Defense and Insurance	395
Ethics, Where Are We? Where Are We Going?— Todd	*816
Fee Collection System	222
Inter-Insurance Exchange—Anson	le321
Services, Council on (HSA)	395
Students and Residents on MSNJ Committees and Councils	313
Medicine and Religion, Committee on	59
Membership Inquiry and Complaint Committees, Termination of	394
Mesmerism: A Translation of the Original Medical and Scientific Writings of F.A. Mesmer, M.D.	br153
Microfilming, Society's Transactions	312
Middle-Age Crisis: A Preventive Approach— Apolito	cm603
MII-E—Subordinate Loan Payments to	222
Miller, Edward—American Physician (1760-1812)— Chinard	*296
Miller, George W., Jr., M.D., Montclair	*523
Minzter, Albert, M.D.	e871
Moore, Dorothy P.	†853
Morales, Rafael G.	†783
Morse, Dale L., M.D., Albany, NY	*591
Dryden, M.D.	le620
Moskowitz, Sam	le846
Moss, Edward G., M.D., Camden	*369
MSNJ Auxiliary	841, 918
Charter Change	58, 222
Dues—Payment on Installment Plan— Resolution #19	615
Evaluation of by American Society of Association Executives	313
Membership	222, 310
Representation at Hospital Staff Meetings	478
Mucosal Biopsy in Evaluation of Inflammatory Bowel Disease—Rickert	†181
Muehsam, Gerald E., M.D., Short Hills	sa44
Muendel, Harold J.	†71
Multicentric Endobronchial Granular Cell Myblastoma—Davessar, Farmer; Becker	*41

Murillo, Jeremias L., M.D., Newark	*598, *832
Murray, Norman L.	†853
William, M.D., Perth Amboy	*379

N

Najem, G.R., M.D., Newark	*527
Naso, Ann Marie, B.T., Montclair	*439
National Cancer Institute Clinical Center Study	140
Neck Injuries in Football Players—Sherk; Watters ..	*579
Needham, Larry L., Ph.D., Atlanta, GA	*591
Nephrocutaneous Fistula—Karfopoulos; Murray; Stone	*379
Neuroendocrine Diagnostic Tests in Psychiatry—Extein; Pottash; Gold	*731
New Jersey Foundation for Health Care Evaluation	59, 136, 229, 316, 396, 479, 552
Jersey Foundation for Health Care Evaluation Discontinuance of—Resolution #33	615
Jersey Graduate Medical Education Program	396
Jersey Health Maintenance Organizations (HMOs)—Status Report on— 1980—Ferrand	sa457
Jersey Medical School Delegation Report on AMA Interim Meetings	310
Jersey Programs and Services Related to Adolescent Pregnancy: Resource Book	329
Newborn Record Log Book	59
Nineteenth Century Drug Therapy: Computer Analysis—Cowen; King	mh758
Nissenblatt, Michael J., M.D., Piscataway	*453
Nominating Committee, Report of	219, 309
Nonsurgical Evaluation and Management of Malignant Biliary Tract Obstruction— Loigman; Mattern; Healey; Hayes	*883
Notes on a Bygone Practice in a North African Country—Calo	mh606
Nuclear Conflict—Senator Bradley	le141
Conflict—Senator Williams	le141
Conflict, More On—Hiatt	le230
War—Williams	le64
Nurse/Midwife Regulations	222, 310
Nussbaum, Murray	†704
Nutrition Committee of Hospital Medical Board, Recommendations	695
Support Team—Bedell; Seltzer; Stocum; Catildi-Betcher	le553
Update	128, 217, 300, 473, 611, 762, 834
Nutritional Support of the Hospitalized Patient— Seltzer; Fletcher	*291

O

Obituaries	70, 151, 240, 326, 407, 484, 558, 626, 704, 783, 852, 928
O'Brien, John G.	†241
O'Grady, James J.	†853
Opposition to Federal Subsidy of HMOs— Primich	le142
Oral Phosphates Treatment of Hypercalcemia in Pregnancy—Levy; Pierucci; Stroup	*113
Orifice, The Forgotten—Stroup	*283
Osteopath's Use of M.D. Designation	691
Ownership Statement	839

1-76—Jan.	333-412—May
77-156—Feb.	413-488—June
157-248—Mar.	489-564—July
249-332—April	Tr1-Tr72—July
	565-632—Aug.

633-710—Sept.
711-790—Oct.
791-858—Nov.
859-942—Dec.

P

Pacemakers, Removal of—Cornell; Jacobs	le620
Removal of—Morse; Gooch	le620
Palmer, Hugh D., M.D.	le232
Parment, Morris	*71
Partnership, Not Domination—Goracci	*435
Pasquale, Thomas L.	*71
Pasternack, Elroy	t484
Pasteur—Kler	mh121
Patel, Rajnikant, M.D., Brooklyn, NY	*737
R., M.D., Newark	*374
Patients' Rights: Where Are We? Where Are We Going?—McIntyre	*809
Pediatric Briefs	131, 303, 391, 542, 684, 836, 909
Pediculosis Upsurge—Smith	cn51
Pello, Mark J., M.D., Camden	cn907
Pelosi, Marco A., New Providence	*195
Petrauskas, Stasys	t627
Phillips, Ralph S.	t853
Physician Careers and an Academic Health Science Center—Fox; Blackburn	*443
in Today's Society	e803
Due Process in Applying for Hospital Privileges— George; Quattrone	sa207
Recruitment and the Hospital	br243
Physicians Art Association	695
Drug Manual	br929
and Gun Control	e426
and Gun Control—Baran	le621
Seeking Location in New Jersey	61, 137, 225, 317, 397, 480, 549, 617, 696, 771, 841, 920
Pierucci, Louis, M.D., Camden	*113
Pinck, Bernard D.	t241
Plotkin, Ray	t853
Pogoloff, Samuel H.	*705
Postgraduate Physician Training in New Jersey, CMDNJ and—Marshall	sa903
Pottash, A.L.C., M.D., Summit	*731
Practical Pediatrics: Selected Abstracts	br854
Prolactin and Its Physiology: Part I—Kemmman; Jones	*741
Prenatal Diethylstilbesterol (DES) Exposure	br706
Preparticipation Evaluation for School Athletic Programs—Hirsch; Hirsch; Reedman; Rineberg; Weiss	*585
Prescription, Amendments on Requirements for Issuing a	220
Preventive Measures—Goldstone	le143
Previti, Francis W., M.D., Atlantic City	*289
Primary Mediastinal Lipoma—Sarama, DiGiacoma; Safirstein	*901
Primich, Frank J., M.D.	le142
Prisoners of Pain	br152
PRN 1981-66: A Dangerous Medicaid Regulation ...	e722
Pro-Competition: Panacea for Rising Health Care Costs or Just the Opposite?	cm911
Professional Liability Commentary	13, 84, 166, 257, 340, 421, 497, 573, 641, 718, 800, 866
Liability Insurance	478
Liability Update	224
Profile of the Residency-Trained Family Physician in the United States, 1970-1979	br628
Pseudo-Bladder Neck Syndrome in Women: Value of Gray-Scale Ultrasonography—Gould; Patel; Burbella	*374
Psychiatric Care, Insurance Benefits for	223

Psychiatry, A Method of	br328
Neuroendocrine Diagnostic Tests in—Extein; Pottash; Gold	*731
Public Relations, Council on	395
Publication, Committee on	59, 312
Punch Cures the Gout—Wedeen	*201
Pyogenic Liver Abscess Secondary to a Toothpick Penetrating the Gastrointestinal Tract— Rafizadeh; Silver; Fieber	*377

Q

Quattrone, Madelyn Schwartz, Woodbury	sa207
---	-------

R

Radiological Services to Chiropractors	58, 222, 310, 394
Rafizadeh, Farhad, M.D., Livingston	*377
Rajkumar, Solomon V., M.D., Brooklyn, NY	*737
Rape, Myths, Misconceptions, Facts and Interventions—Shrier	*668
Read, George R.	*705
Hilton S., M.D.	le64
Recertification by Examination: "Trick or Treat"— Bernstein	e170
Rectal Ulcer, Solitary—Lifschultz; Carone; Vrla	*116
Reedman, Lynn, C.M.A., Bridgewater	*585
Reference Committee "H"	616
Regulation on Schedule II Drugs	915
Reichenberger, Anton J., B.S.M.E., NYC	*271
Renal Failure, Current Patterns of Acute— Donatelli	*819
Retired Physicians—Magnes	le64
Retirement Plan for Physicians	59, 395
Retrograde Ventriculo-Atrial Conduction in Complete Antegrade Atrioventricular Block— Agarwal	c125
Rhabdomyolysis with Acute Renal Failure in Legionnaire's Disease—Gartenberg; Weinstein; Fernando; Dodelson; Ribot	*119
Ribot, Seymour, M.D., Newark	*119
Rickert, Robert R., M.D., Livingston	*181
Rigolosi Appointed	e263
Riley, David J., M.D., Piscataway	*187
Rineberg, Bernard A., M.D., Piscataway	*585
Ringside Physicians, Ethnic Aspects of Boxing and the—Williams	*654
Rockefeller Foundation, Conquest of Yellow Fever— Bowers; King	mh539
Rodriguez, Silvio R., M.D., Philadelphia, PA	*93
Roe, The Honorable Robert A., Washington ..	*54, le402
Role of Humanities in a Medical Education: Attitudinal Survey of Members of the Faculty Council of the NJ Medical School—Klein	477
Romano, Phyllis—President, MSNJ Auxiliary	433
Rosen, Frank L., M.D.	le232, t853
Rosenberg, Norman, M.D., New Brunswick	*532
Rossi, Generoso	t853
Roth, Daniel B.	t407
Rothfeld, Edwin L., M.D. Newark	c48
Rothman, Donald, M.D., Red Bank	cn50, cn538, cn681
Sidney A.	t853

*—Original Article
†—Obituary
br—Book Review
c—The Electrocardiogram

cm—Commentary
cn—Clinical Note
e—Editorial

le—Letter
mh—Medical History
sa—Special Article
tr—Transactions

Rowen, Manuel, M.D., Elizabeth	*99
Rowland, John H.	*71
Rubin, Robert J., M.D., Plainfield	*887
Russo, Richard J., M.S., Trenton	*889
Richard M., M.D., New Brunswick	*737
Ryan, Beverly R., M.D., Newark	*658

S

Saffron, Morris H., M.D.	622
Safirstein, Benjamin H., M.D., Newark	*751, *901
Same-Day Surgery, Proposed Rule on	917
Sanfacon, Thomas A.	*558
Sarama, Robert F., M.D., Newark	*901
Savitsky, J. Philip, M.D., Pearl River	*26
Saxanoff, Seymour, M.D., Piscataway	*187
Schedule II Drugs, Proposed Regulation on	915
Schenker, Israel N.	*854
Schildkraut, Jacob M.	*854
Schizophrenia, "Silent" Acute Abdomen of—	
Apter	*679
Schmidt, Clifford M.	*559
Schneider, Louis A.	*71
Schnipper, Edward F., M.D., Piscataway	*453
School Athletic Programs, Preparation Evaluation	
for—Hirsch; Hirsch; Reedman; Rineberg;	
Weiss	*585
Schulsinger, Samuel	*485
Schwartz, Melvin, M.D., Piscataway	*453
Scoliosis Bracing, Modern Concepts of—	
Fernand; Stefanelli; Ernst	*22
Seizures and Sports—Fellman	le845
Selling Surgical Care—Goldstein	le553
Seltzer, Murray H., M.D., Livingston	*291, le553
Senate Bill S-382	311
Sexual Consequences of Disability	br72
Shah, Hemendra, M.D., Newark	*663
Sheehan, Daniel C.	*241
Sherk, Henry H., M.D., Camden	*579
Sherman, Richard, M.D., Westfield	*748
Shor, David M.	*705
Shrier, Diane K., M.D.	*668
Sibert, Scott L., M.D.	le142
Sigmoid Volvulus, Detorsion of, by Flexible Fiber-	
optic Sigmoidoscopy—Previti, Holt	*289
"Silent" Acute Abdomen of Schizophrenia—	
Apter	*679
Silver, Harvey, M.D., Livingston	*377
Sims, Richard V.	*559
Sister Mary Joseph Node—A Clue to	
Internal Malignancy—Schnipper;	
Nissenblatt; Schwartz; Ludwig	*453
Slocum, Bernadette A., B.S.	le553
Smith, Leon A.	*71
Leon G., M.D., Newark	cn51, le232
Percy L.	1929
Society Changes Name—Gardam	le554
Soll, Raphael I.	*326
Solomon, Sheldon D., M.D., Cherry Hill	*369, *893
Somers, Anne R.	cm 911
Somjen, Gabor, M.D.	le554
Somol, Sister Helen, R.N., Montclair	*439
Soschin, Samuel J.	*854
Sound Sleep	br153
Special Committees and Liaison Representatives	767

Spencer, Alvan	*71
Spindell, Lloyd N., M.D., Newark	*663
Stanowicz, Steven J.	*407
State Board of Medical Examiners, Actions of	478
Board of Medical Examiners, Rule 13:35-6.6—	
The Prescription Blank	221
Board of Medical Examiners, Term of Service on	
(Substitute Resolution #24)	615
Board of Medical Examiners, Versus	
Driggs	58, 394, 478
Stefanelli A. E., M.D., Newark	*22
Stein, Adalbert	*326
William	*485
Stier, Arleane, R.N., Montclair	*439
Stinemam, Robert G.	*627
Stitelman, Martha, M.D., Summit	*530
Stone, Frederick J., M.D.	*379
Stroke, The History of My—Muehsam	sa44
Stroup, Paul M.D., Camden	*113, *283
Student Financial Aid	692
Financial Aid Program	915
Medical Loan Fund	916
Stuart, James E.	*151
Subordinate Loan	691
Suburban Consultant: A Personal Philosophy	le621
Suffness, Gustave	*627
Sussman, Barry, M.D., Englewood	*173
Sylvia, Lawrence C., M.D., Long Branch	*600

T

Talmage, Walter R.	*241
Tator, Arthur E.	*628
Teenage Nutrition	e723
Teichholz, Max H.	*485
Tepper, Erwin, M.D., Long Branch	*600
Terwedow, Henry A.	*783
Therapeutic Drug Information	52, 211,
389, 471, 544, 682, 765	
Thimerosal, Delayed Sensitivity to, in Contact Lens	
Solutions—Zeigen; Jacobs; Weinberger	*362
Thind, Inderjit S., M.D., Newark	*527
Thompson, James P., M.D., Patterson	*825
Thrombosis of the Pampiniform Plexus—	
Rothman	cn681
Titelbaum, Jules A., M.D., Newark	*598, *832
Todd, James S., M.D., Ridgewood	e804, *816
Tomlins, Francis I.	*327
Toward the Conquest of Cancer	br243
Transluminal Angioplasty—Byrne	le321
Transurethral Resection in a Two-Year-Old Boy—	
Boorjian	*39
TRS-80 (TM) and the Surgeon—Rothman	cn538
Trustees' Minutes:	
November 16, 1980	58
December 21, 1980	223
February 1, 1981	310
March 15, 1981	394
April 12, 1981	478
May 19, 1981	614
July 19, 1981	691
September 20, 1981	915
T-Tube Removal—Barnett	le775
Tuberculosis Classification and Treatment—	
Palmer	le232
Turner, Charles F.	*628

1-76—Jan.
77-156—Feb.
157-248—Mar.
249-332—April

333-412—May
413-488—June
489-564—July
Tr1-Tr72—July
565-632—Aug.

633-710—Sept.
711-790—Oct.
791-858—Nov.
859-942—Dec.

U

Ulmer, Chester I.	†327
David H.	†628
Ultrasonic Imaging of the Cervical Carotid Arteries— Hobson; Berry; Marsters; Katocs; Sevitsky	*26
Unfair Claims Settlement Practices	224
Unrecognized Bladder Diverticulum: Cause of Persistent Urinary Tract Infection— Kissinger; Beaugard; Affuso	*677
Update on Medicare Legislation—Hughes	le142
Urinary Tract Infection, Unrecognized Bladder Diverticulum as Cause of—Kissinger; Beaugard; Affuso	*677

V

Vander Veer, H. Garrett	†854
Ventnor Foundation, The	e18
Foundation, The—Read	le64
Verzosa, Oscar, M.D., Elizabeth	*897
Videtti, Joseph F.	†151
View of the Presidency, A—Baker	*467
Vreeland, Ralph J.	†71
Vrla, R., M.D., Chicago	*116

W

Wagner, Bernard, M.D., Philadelphia	*754
Walker, Levi M.	†151
Walters, Thomas R., M.D., Newark	*658
Ward, Albert J.	†408
Lawrence L., M.D., Fort Defiance, AR	cn469
Waters, Edward G.	†705
Watson, Frank Y., M.D.	le143
Portia B., R.D., Montclair	*439
Watters, William C., M.D., Camden	*579

Wedeen, Richard P., M.D., East Orange	*201
Weeping May Tarry: My Long Night With Cancer	br152
Weinberger, George I., M.D., Newark	*362
Weinert, Henry V.	†485
Weinstein, Melvin P., New Brunswick	*119
Weisbrot, Frederick J., M.D., East Orange	*351
Weiss, Andrew B., M.D., Newark	*585
Weisse, Allen B., M.D., Newark	*513
Westerman, S. Thomas, M.D., Shrewsbury	*600
What To Do When You Think You Can't Have A Baby	br706
What Your Patients Are Reading: DRG	e577
White, Robert R.	†929
Wiley, F. Parker	†241
Williams, Honorable Harrison A., Jr.	le64, le141
Paul T., M.D.	*654
Wolowitz, Harry B.	†559
Wurzel, Milton	†705

X

X-ray Technicians Limited Certification	222
---	-----

Y

Yellow Fever: Conquest of: The Rockefeller Foundation—Bowers; King	mh539
Your Fabulous Volunteers	br408

Z

Zaorski, John	†783
Zeigen, Scott R., B.A., Newark	*362
Zeiger, Louis S., M.D., Camden	*451
Zondlo, Frank C., M.D.	le141

*—Original Article
†—Obituary
br—Book Review
c—The Electrocardiogram

cm—Commentary
cn—Clinical Note
e—Editorial

le—Letter
mh—Medical History
sa—Special Article
tr—Transactions

RESTORED BUCKS COUNTY BARN

Behind the bank barn door you'll find 4 levels of living space which one can truly live out their fantasy. Cook Henry the VIII meals in your gourmet kitchen with your own wet bar and enjoy every morsel in your 23' dining room. Marvel at the stone, brick, slate and exposed beams throughout. Four bedrooms, 3½ baths, stone corral for your real or unreal pony. If you like the unusual and dare to be different, reserve your appointment today. Only 40 minutes to Princeton and only \$425,000.

Call for more information
215-794-7403
Elizabeth James Country Real Estate
Route 202, Lahaska, PA 18931

FOR SALE MEDICAL/PROFESSIONAL OFFICE

- One block from PAUL KIMBALL HOSPITAL
- On major highway Route 9, Lakewood, N.J.
- Ample parking space

CALL (201) 542-3382
Monday-Friday 9 AM-5 PM
Evenings (201) 464-2063



Mountainside Center Professional Building

at the junction of Franklin Lakes, Wyckoff and North Haledon.

- Ideal location positioned strategically at the gateway of North Jersey's most affluent residential area.
- Occupancy December 1, 1981
- Three floors with elevator (7,300 square feet each level)
- Will divide
- Architectural masterpiece
- On site parking more than ample
- Owners will be tenants
- Very competitive rents

Call 201-427-7745 or
201-427-7801

NEW BRUNSWICK HOME FOR SALE

Charm and elegance grace this most luxurious ranch home on spacious landscaped lot in the finest suburban area of New Brunswick. 4 bedrooms, 5 baths, living room, dining room, eat-in kitchen, den, porch, patio, 2 car garage, finished basement with soda fountain, central AC, intercom, many extras. 5 minutes to downtown New Brunswick, furnished, \$179,900.

Feller & Feist Agency
(201) 249-9100

LEASE OFFICE

Selected specialties (dermatology, ophthalmology, industrial medicine, etc.) desired to lease office space in a new medical building. Excellent promise for thriving practice; suitable for initial location or as a second office.

Please contact East Gate Medical Building, Church Street and Gaither Drive, Mount Laurel, New Jersey 08054. (609) 235-1120.



SPLENDID TUDOR

Handcarved woodwork, dramatic sunken FR with ceiling-high fireplace, luxurious private Master Bedroom suite, 4 bedrooms, Rec rm. w/fireplace, central air, 5 zone gas HW BB heat and much more! \$479,000

25 minutes from NYC
Close to Rts. 280, 287, 80, 23, 46, & 10.

LEON REAL ESTATE CO. 201-228-5503

CLASSIFIED ADVERTISEMENTS

CARDIOLOGIST—Board eligible. Seeks simple or multi-specialty group practice, partnership in South or Central New Jersey. Invasive and non-invasive training. Available. G. Myers, M.D., 6324 Alderson St. Pittsburgh, PA 15217.

FAMILY PRACTITIONER—Board eligible. Seeking group practice or partnership in Central New Jersey to begin August 1982. No obstetrics. Write Catherine Sharkness, 6 Darthmouth Avenue, Apt 2-A, Bridgewater, NJ 08807. Call 526-9626 after 6 PM.

GENERAL SURGEON—University trained. Doing a fellowship in vascular surgery. Seeks position for August 1982. Contact Ruben J. Delgado, M.D., Spring Ridge M-26, Whitehall, PA 18052.

INTERNIST—ABIM, experience in private practice and medical administration. Desires to associate or buy. Write Box No. 282, c/o JMSNJ.

INTERNIST—Residency completed June 1981. Seeks association with another internist or medical clinic. Available immediately. Dr. (Mrs.) Sarup G. Nariani, 149 Dafrack Drive, Lake Hiawatha, NJ 07034. (201) 334-7673

INTERNIST-ENDOCRINOLOGIST—ABIM certified B.E. endocrinology. Age 32. Seeks group practice or endocrin partnership. Available July 1982. Write Box No. 280 c/o JMSNJ.

INTERNIST-GASTROENTEROLOGIST—ABIM, AOA, age 29, university trained. Skilled in all endoscopic procedures. Seeks group, partnership in New Jersey. Write Box No. 283, c/o JMSNJ.

INTERNIST-RHEUMATOLOGIST—ABIM, both with excellent clinical teaching/practice experience. Desires association with sub-specialty group/partnership in New Jersey. Write Box No. 270, c/o JMSNJ.

M.D.—Interested in covering or taking over general practice in Northern NJ. Evening hours preferred. Write Box No. 281, c/o JMSNJ.

PEDIATRICIAN—Board certified. Seeks part-time pediatric work in any setting one weekday and/or weekend in South Jersey. Write Box No. 287 c/o JOURNAL MSNJ.

PHYSICIAN—ABIM eligible. Specialty internal medicine (cardiology). Desires hospital based, solo, partnership or group association. Available July 1982. Write Box No. 284, c/o JMSNJ.

PHYSICIAN—Board certified, internal medicine. Specialty cardiology and internal medicine. Desires solo, group, partnership or hospital based. Available July 1982. Write Box No. 285, c/o JMSNJ.

PSYCHIATRIC RN—Experienced, seeks position in physician's office or other related out-patient facility. Please call (201) 289-6672.

PHYSICIAN—G.P., board certified family practice medicine. Desires full-time office, clinic or ambulatory hospital affiliation in North Jersey. Vast experience treating alcoholics. DEA number current. Call (609) 692-0244 weekdays, weekends 'till midnight. If no answer, write Samuel Saland, M.D., Brentwood Towers, Apt. 304, 67 Howard Street, Vineland, NJ 08360.

OTOLARYNGOLOGY—Board certified with broad experience. Will cover part time, solo or group practice. Available now. Write Box No. 286, c/o JMSNJ.

RADIOLOGIST/DIAGNOSTIC—Trained in all phases. Available for part-time locums and consultation service in Northern New Jersey. Contact Box No. 275, c/o JMSNJ.

NEEDED—M.D.—Board eligible or certified internist-cardiologist to associate with group in rapidly growing area in Ocean County NJ. Salary with eventual partnership. Please send curriculum vitae to Box No. 261, c/o JMSNJ.

NEEDED—PULMONOLOGIST & CARDIOLOGIST—Position available in Central New Jersey; join small group private practice. Write Box 11, Hazlet, NJ 07730.

NEEDED—ORTHOPEDIST—To associate with and rapidly acquire busy practice in Winston-Salem, NC. Financial arrangements designed to meet specific needs of associating physician. Respond with C.V. to Box No. 279 c/o JMSNJ.

NEEDED—ASSOCIATE—Pediatrician, board certified seeks associate for moderate size Middlesex County practice with unhurried atmosphere and individual patient care. Excellent deal with early equal partnership. Write Box No. 273, c/o JMSNJ.

FOR SALE—Home/Office/Furnishings, due to death of GP. Small town location. N.W. New Jersey. Two hospitals nearby. Excellent opportunity for family practitioner or internist. Call (201) 689-1705.

OFFICE SPACE—2 Locations—To rent or share, furnished, very reasonable. Fair Lawn, Bergen County and also in Ridgewood, Bergen County. Write Box No. 273, c/o JMSNJ.

OFFICE SPACE—For Rent, medical office space, new and fully equipped, part/full time. Ocean Medical Park, Bricktown, NJ 08723. Call (201) 295-9003.

OFFICE SPACE TO SHARE—With semi-retired Cranford physician. Share all facilities. Well established office. Main street, ample parking. Call (201) 276-0009.

OFFICE SPACE—Kenilworth. For rent, medical office. Call (201) 272-5750.

OFFICE SPACE—Lumberton. Available for subletting at 337 North Main St. About 1/2 mile from Burlington County Memorial Hospital, Mt. Holly. Please contact telephone number (609) 261-4060 or write P.O. Box 409, Lumberton, NJ 08048.

OFFICE SPACE—Middlesex County, Edison. Attractive new building centrally located, near hospitals, major highways. Last section, 775 square feet available. Sub-specialties needed. M.R. Bronstein, M.D., (201) 738-8000.

OFFICE SPACE—Moorestown. Space to rent, 701 E. Main Street. Custom medical offices in the new wing. Building to be completed winter 1981. (609) 235-2651.

OFFICE SPACE—Professional Office Available, Morris County, N.J. (201) 366-2557.

OFFICE SPACE—Northern NJ. Available one private exam room and share fully furnished waiting room, business office, auxiliary exam room. Excellent exposure, close to hospital, near major hwy's., 30 minutes to NYC. Call evenings (201) 337-1627.

OFFICE SPACE—Northern NJ. Available to share. Call (201) 945-3354.

OFFICE SPACE—Doctor's office fully equipped and furnished. Equipment and furnishings may be purchased. Lease available. Small modern medical building, parking. Call (201) 273-8040.

OFFICE SPACE—Roselle Park. Medical office space, 800 ft. \$530/month & utilities. 744 Galloping Hill Rd. Upper level front. Recently decorated. Sublease up to nine years. (201) 241-1800.

OFFICE SPACE—Watchung. 5500 ft. Professional office space. Will subdivide. On site parking. Excellent location on Mt. Boulevard. Available immediately. Call (201) 232-9190 or (201) 272-4867 after 6 p.m.

OFFICE SPACE—West New York, New Jersey. For rent. Prime location on main street. Call (201) 278-1000.

INFORMATION FOR MEMBERS—RATES:—\$5.00 per insertion up to 25 words; 10 cents each additional word. Payable in advance. **WORD COUNT:** Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, and "Write Box No. 000, c/o JMSNJ as six words. **COPY DEADLINE:** Fifth of preceding month.

NEEMA EMERGENCY MEDICAL
—a professional association—

Emergency Medicine Positions—available with emergency physician group in FL, PA, NY, NJ, VA, WV, KY, MD and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to:

NEEMA Emergency Medical

Suite 400

399 Market Street

Philadelphia, Pa. 19106

or phone

in Pa., (215) 925-3511

outside Pa., 800-523-0776

**RESIDENCY IN
PHYSICAL MEDICINE
AND REHABILITATION**

Dynamic, young program with balanced academic and clinical emphasis under the supervision of 10 physiatrists. Three year program and integrated internship/residency with opportunity for research and pursuit of special interest both in medical school and private hospital settings. Stipends from \$17,500 to \$20,100 depending on qualifications. We will pay for visits in selected cases. Equal Opportunity/Affirmative Action Employer. Telephone or write for information to:

John F. Ditunno, Jr., M.D., Director
Department of Rehabilitation Medicine
Thomas Jefferson University Hospital
11th and Walnut Street
Philadelphia, Pa. 19107
Telephone: (215) 928-6573

INDUSTRIAL PHYSICIAN

An opportunity is currently available for a physician to practice in our central New Jersey industrial clinic. The opportunity includes possible advancement to company medical directorship. Competitive starting salary with merit increments. Excellent benefits including malpractice insurance and CME allowance. No week-end or evening duty. New Jersey license required. Please send *salary requirement* and curriculum vitae to:

Box No. 278, c/o JMSNJ

2 Princess Road

Lawrenceville Rd., N.J. 08648

PRIMARY CARE FAMILY PHYSICIANS

For new hospital based practice in Northern New Jersey, 55 min. from New York City. Beautiful country area.

Send C.V. to: Mrs. Davis, Dir., Personnel, Wallkill Valley General Hospital, 20 Walnut St., Sussex, NJ 07461. Equal opportunity employer.

TRANSACTIONS

981 House of Delegates

215th ANNUAL MEETING

LIBRARY
U.C. SAN FRANCISCO

JUL 28 1981

The Medical Society of New Jersey

May 16-19, 1981

Index

Pages Tr 2-Tr 3

Division
San Francisco
Calif. 94143

1980 Transactions

At its first session on Saturday, May 16, 1981, the House of Delegates approved the Transactions of the 1980 House of Delegates as published in the July 1980 Transactions issue of *The Journal*.

Action To Limit Debate

At its first session on Saturday, May 16, 1981, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject except in rebuttal or by express permission of the House, and that floor time in each instance shall be limited to four (4) minutes unless exception is made by the House.

Reports and resolutions, and the actions thereon, are included under the Reference Committee to which they were assigned. The House takes action only on the "Resolved" sections of a resolution.



Officers and Trustees

PRESIDENT	Armando F. Goracci, M.D. (Gloucester)	Woodbury
PRESIDENT-ELECT	Howard D. Slobodien, M.D. (Middlesex)	Perth Amboy
FIRST VICE-PRESIDENT	Alexander D. Kovacs, M.D. (Union)	Scotch Plains
SECOND VICE-PRESIDENT	Frank Y. Watson, M.D. (Essex)	Montclair
IMMEDIATE PAST-PRESIDENT	Augustus L. Baker, Jr., M.D. (Morris)	Dover
SECRETARY	Arthur Bernstein, M.D. (Essex)	East Orange
TREASURER	Rudolph C. Gering, M.D.(Mercer)	Pennington

Trustees

CHAIRMAN	William Greifinger, M.D. (1984) (Essex)	Belleville
	Meyer L. Abrams, M.D. (1982) (Burlington)	Cherry Hill
	Frank Campo, M.D. (1984) (Mercer)	Trenton
	Douglas M. Costabile, M.D. (1984) (Union)	Murray Hill
	John J. Crosby, Jr., M.D. (1984) (Hudson)	Jersey City
	Anthony P. DeSpirito, M.D. (1982) (Monmouth)	Neptune City
	Ralph J. Fioretti, M.D. (1983) (Bergen)	Rochelle Park
	Palma E. Formica, M.D. (1984) (Middlesex)	Old Bridge
	Henry W. Fullerton, Jr., M.D. (1982) (Salem)	Carney's Point
	Sherman Garrison, M.D. (1983) (Cumberland)	Bridgeton
	John P. Kengeter, M.D. (1984) (Ocean)	Toms River
	Myles C. Morrison, Jr., M.D. (1982) (Morris)	Morristown
	Michael R. Ramundo, M.D. (1984) (Passaic)	Clifton
	Bernard Robins, M.D., (1983) (Essex)	Springfield

Councilors

FIRST DISTRICT	(Essex, Morris, Union, and Warren Counties)	
	Edward M. Coe, M.D. (1984)	Cranford
SECOND DISTRICT	(Bergen, Hudson, Passaic, and Sussex Counties)	
	Robert A. Weinstein, M.D. (1983)	Newton
THIRD DISTRICT	(Hunterdon, Mercer, Middlesex, and Somerset Counties)	
	Albert F. Moriconi, M.D. (1982)	Trenton
FOURTH DISTRICT	(Burlington, Camden, Monmouth, and Ocean Counties)	
	Frederick W. Durham, M.D. (1984)	Haddonfield
FIFTH DISTRICT	(Atlantic, Cape May, Cumberland, Gloucester, and Salem Counties)	
	Ronald M. Fisher, M.D. (1983)	Bridgeton

AMA Delegates

Alfred A. Alessi, M.D. (1982)	Hackensack
William J. D'Elia, M.D. (1981)	Spring Lake
Frederick W. Durham, M.D. (1982)	Haddonfield
Karl T. Franzoni, M.D. (1982)	Trenton
John S. Madara, M.D. (1982)	Salem
Henry J. Mineur, M.D. (1982)	Cranford
Myles C. Morrison (1981)	Morristown

July Transactions 1981

Publication Committee

Paul J. Hirsch, M.D., *Chairman*
Dirck L. Brendlinger, M.D.
Julio C. del Castillo, M.D.

Editor

Arthur Krosnick, M.D.

Managing Editor

Marjorie D. Treptow

Advertising Manager

E. Elizabeth Cookson

Executive Director

Vincent A. Maressa

Executive Director Emeritus

Richard I. Nevin

Editorial Board

Jerome Abrams, M.D.
Harold Arlen, M.D.
Alfonse Cinotti, M.D.
Stuart D. Cook, M.D.
Robert Dodelson, M.D.
Wm. A. Dwyer, Jr., M.D.
Norman H. Ertel, M.D.
A. Olusegun Fayemi, M.D.
Arthur Goldfarb, M.D.
Robert A. Goldstone, M.D.
Murray Kahn, M.D.
Monroe S. Karetzky, M.D.
Avrum L. Katcher, M.D.
Sidney Keteyor, M.D.
Bernard J. Koven, M.D.
Joel D. Levinson, M.D.
Henry R. Liss, M.D.
Robert M. MacMillan, M.D.
Geobel A. Marin, M.D.
Murray Nussbaum, M.D.
Christopher M. Papa, M.D.
Victor Parsonnet, M.D.
Irwin Pollack, M.D.
Bernard A. Rineberg, M.D.
Edwin L. Rothfeld, M.D.
Benjamin F. Rush, Jr., M.D.
Morris H. Saffron, M.D.
Mark M. Singer, M.D.
Leon G. Smith, M.D.
Sheldon D. Solomon, M.D.
Lloyd N. Spindell, M.D.
A. Arthur Sugerman, M.D.
Robert B. Zufall, M.D.

The Journal of the Medical Society of New Jersey (ISSN-0025-7524) is published monthly (since 1904) except semi-monthly in July (13 issues), under direction of the Committee on Publication, by the Medical Society of New Jersey, Two Princess Road, Lawrenceville, N.J. 08648. Printed in East Stroudsburg, Pa. by the Hughes Printing Co. Whole number of issues 927. Member's subscription (\$10) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$6.50 for postage. Single copies, \$1. Address communications to *The Journal* MSNJ, 2 Princess Road, Lawrenceville, N.J. 08648 (609) 896-1766. Second-class postage paid at Trenton, N.J. and additional entry office. Copyright 1981 by the Medical Society of New Jersey.

INDEX

	Reference Committee	Page
Affirmation of Principles Regarding Unnecessary Regulation—Resolution #6	"E"	Tr 51
Alternate Delegates, Seating of—Resolution #13	"A"	Tr 18
AMA Department of Negotiations—Resolution #38E	"A"	Tr 20
Dues, New Dues-Paying Methodology for State and—Resolution #34	"B"	Tr 31
Mandatory Membership in—Resolution #20	"Const. & Bylaws"	Tr 8
Membership, New—Resolution #27	"B"	Tr 30
Policy on Physicians' Assistants (Board of Trustees' Item)	"A"	Tr 11
Annual Meeting	"H"	Tr 68
Meeting, Changing Structure of the—Resolution #35	"H"	Tr 71
Attendance	Inside back cover	
Benefit Payments to Physicians, Transmittal of Assignment—Resolution #4	"C"	Tr 39
Blue Cross Coverage for Rehabilitation Treatment—Resolution #3	"C"	Tr 38
Board of Trustees	"A"	Tr 10
Buchanan, Ralph M.L., M.D.—1907-1980—Memorial Resolution	"A"	Tr 4
Bylaws, Amendment to	"Const. & Bylaws"	Tr 5
Cancer Control	"G"	Tr 64
Chemical Dump Explosion in Elizabeth (Board of Trustees' Item)	"G"	Tr 62
Child Health	"G"	Tr 64
Chronically Ill and Aging	"G"	Tr 63
CME Requirements, Discontinue Mandatory—Resolution #17	"D"	Tr 43
Constitution and Bylaws, Revision of	"Const. & Bylaws"	Tr 5
Credentials	"A"	Tr 15
Diagnosis Related Groups (Board of Trustees' item)	"F"	Tr 53
Related Groups, Opposition to—Resolution #8	"F"	Tr 58
Related Groups (DRGs) Opposition to—Resolution #14	"D"	Tr 59
Discontinue Mandatory CME Requirements—Resolution #17	"D"	Tr 43
Drug and Alcohol Abuse	"F"	Tr 56
Dual Fee System—Resolution #30	"C"	Tr 39
Dues-Delinquent Members, Reinstatement Policy for (Board of Trustees' Item)	"B"	Tr 23
Paying Methodology for State and AMA Dues, New—Resolution #34	"B"	Tr 31
Payment of on Installment Plan—Resolution #19	"B"	Tr 29
Election	"D"	Tr 72
Emergency Medical Care	"D"	Tr 42
Emeritus Membership, Nominations for	"H"	Tr 69
Environmental Health	"G"	Tr 65
Equal Rights for Men and Women—Resolution #37	"A"	Tr 20
Excessive Fee Regulations of the State Board of Medical Examiners—Resolution #40E	"A"	Tr 21
Executive Director	"A"	Tr 14
Fall and Spring Conferences (Board of Trustees' Item)	"A"	Tr 11
Family Medicine Department, Fund for—Resolution #32	"D"	Tr 43
Finance and Budget	"B"	Tr 25
Five-Digit Procedure Coding—Resolution #18	"F"	Tr 60
Fund Family Medicine Department—Resolution #32	"D"	Tr 43
Government Regulations—Resolution #36	"E"	Tr 52
Health Insurance, Opposition to Further Intrusion by the Federal Government into the Provision of—Resolution #10	"E"	Tr 51
Maintenance Organizations, Discontinuance of Funding for—Resolution #16	"F"	Tr 60
System Agencies, Opposition to—Resolution #9	"F"	Tr 59
System Agencies (HSAs)—Resolution #25	"F"	Tr 61
Hearing and Speech, Conservation of	"G"	Tr 65
House of Delegates, Reapportionment of—Resolution #5	"A"	Tr 17
of Delegates, Size of—Resolution #12	"A"	Tr 18
Impaired Physicians	"F"	Tr 56
IPA/HMO Interim Report	"B"	Tr 22
Insurance Company Fee Disputes—Resolution #31	"C"	Tr 39
Judicial Council	"A"	Tr 12
Late Fee (\$50) for MSNJ Members Paying Current Dues—Resolution #21	"B"	Tr 29
Legal Services Plan (Board of Trustees' Item)	"A"	Tr 11
Services Plan for Physicians, Comprehensive—Resolution #23	"A"	Tr 19
Legislation	"E"	Tr 44
—Supplemental	"E"	Tr 47
To Limit the Term of Service on the State Board of Medical Examiners— Resolution #24	"A"	Tr 20
Limit Debate	Inside front cover	
Long Range Planning and Development	"A"	Tr 15
Mandatory Membership in AMA—Resolution #20	"Const. & Bylaws"	Tr 8
Maternal and Child Care	"G"	Tr 66
Medicaid	"F"	Tr 57
Program, Modification of—Resolution #2	"F"	Tr 58
Medical Aspects of School Sports	"G"	Tr 66
Aspects of Sports, Reinstatement of AMA Committee on (Board of Trustees' Item)	"G"	Tr 62

Benefits, MSP Assignment of—Resolution #1	"C"	Tr 38
Defense and Insurance	"C"	Tr 34
Education	"D"	Tr 41
Liability Insurance Premium Schedule—Resolution #41	"C"	Tr 40
Services	"F"	Tr 53
Services (No Code Orders)	"F"	Tr 54
Student Loan Fund	"B"	Tr 27
Medicine and Religion	"D"	Tr 42
Membership Inquiry and Complaint	"F"	Tr 57
Inquiry and Complaint Committees (Board of Trustees' Item)	"F"	Tr 53
Memorial Resolutions		Tr 6
Mental Health	"F"	Tr 55
MIEE-NJ	"C"	Tr 32
MSNJ Auxiliary Advisory	"H"	Tr 69
MSP Assignment of Medical Benefits—Resolution #1	"C"	Tr 38
National Health Insurance (Board of Trustees' Item)	"A"	Tr 11
New Jersey Foundation for Health Care Evaluation (Board of Trustees' Item)	"B"	Tr 22
Jersey Foundation for Health Care Evaluation, Discontinuance of Funding of the—Resolution #33	"B"	Tr 30
Jersey State Medical Underwriters/Medical Inter-Insurance Exchange of New Jersey	"C"	Tr 32
Jersey Two Dollar Prescription Program for the Elderly—Resolution #26	"F"	Tr 61
No Code Orders	"F"	Tr 54
Occupational Health, Workmen's Compensation and Rehabilitation	"F"	Tr 55
Opposition to Further Intrusion by the Federal Government into the Provision of Health Insurance—Resolution #10	"E"	Tr 51
Orders and Prescriptions by Medical Students, Writing of (Board of Trustees' Item) ..	"A"	Tr 11
Payment of MSNJ Dues on the Installment Plan—Resolution #19	"B"	Tr 29
Perinatal Designation Plan, State (Board of Trustees' Item)	"G"	Tr 62
Physician Guests Attending Third Session of the House—Resolution #22	"A"	Tr 18
Physicians' Assistants, AMA Policy on (Board of Trustees' Item)	"A"	Tr 11
Prescription Program for Elderly, New Jersey (\$2)—Resolution #26	"F"	Tr 61
President	"A"	Tr 9
Private Practice of Medicine, Program Extolling Benefits of the—Resolution #29	"E"	Tr 52
Professional Liability Control, Department of	"C"	Tr 33
Standards Review Organization (PSRO) Legislation, Repeal of—Resolution #7 ..	"A"	Tr 17
Program Extolling Benefits of the Private Practice of Medicine—Resolution #29 ..	"E"	Tr 52
Public Health	"G"	Tr 63
Relations	"E"	Tr 49
Publication	"B"	Tr 28
Reapportionment of House of Delegates—Resolution #5	"A"	Tr 17
Reference Committees:		
"A"		Tr 9
"B"		Tr 22
"C"		Tr 32
"D"		Tr 41
"E"		Tr 44
"F"		Tr 53
"G"		Tr 62
"H"		Tr 68
"H"—Expand Functions of		Tr 71
Constitution and Bylaws		Tr 5
Rehabilitation Treatment, Blue Cross Coverage for—Resolution #3	"C"	Tr 38
Retirement Plan for Physicians	"C"	Tr 36
Rubella Screening of All Health Care Facility Employees (Board of Trustees' Item) ..	"G"	Tr 62
School Sports, Medical Aspects of	"G"	Tr 65
Secretary	"A"	Tr 12
Sludge Dumping, Cessation of (Board of Trustees' Item)	"G"	Tr 62
Snedecor, Spencer T., M.D.—1900-1980—Memorial Resolution		Tr 4
State Board of Medical Examiners, Excessive Fee Regulations of— Resolution #40E	"A"	Tr 21
Board of Medical Examiners, Legislation to Limit the Term of Service on— Resolution #24	"A"	Tr 20
Statute of Limitations—Resolution #28	"E"	Tr 52
Toxic Chemical Waste Stockpile—Resolution #39E	"G"	Tr 67
Transactions, Approval of 1980		Inside front cover
Transmittal of Assigned Benefit Payments to Physicians—Resolution #4	"C"	Tr 39
Treasurer	"B"	Tr 24
Unnecessary Regulations, Affirmation of Principle Regarding—Resolution #6	"E"	Tr 51
Uranium Mining and Milling in New Jersey—Resolution #11	"G"	Tr 67
Vision, Conservation of	"G"	Tr 65

MEMORIAL RESOLUTIONS

The following resolutions were received by the House with sorrowful concurrence.

Ralph M.L. Buchanan, M.D. 1907-1980

Whereas, the Almighty has chosen to call from us His loyal servant, Ralph M.L. Buchanan, M.D.; and

Whereas, during his life Doctor Buchanan served the people of New Jersey as a dedicated and caring physician; and

Whereas, as an Officer, Trustee, and Fellow of the Medical Society of New Jersey he sought to improve the capabilities of New Jersey physicians who served the people of New Jersey; now therefore be it

RESOLVED, that the Medical Society of New Jersey expresses its profound grief at the passing of Ralph M.L. Buchanan, M.D., and extends its heartfelt sympathy to his beloved family; and be it further

RESOLVED, that a copy of this Resolution be spread upon the minutes of this meeting and another copy thereof, suitably inscribed, be sent to the bereaved family of Doctor Buchanan.

Spencer T. Snedecor, M.D. 1900-1980

Whereas, the Supreme Author has summoned our beloved colleague, Spencer T. Snedecor, M.D.; and

Whereas, as a Fellow and Officer of the Medical Society of New Jersey, Doctor Snedecor served the members of this Society, the people of New Jersey, and the profession generally; and

Whereas, by his understanding, dependability, and consideration he won the respect and esteem of all who knew him; now therefore be it

RESOLVED, that the Medical Society of New Jersey record its lasting indebtedness to Spencer T. Snedecor, M.D., the 144th President of the Medical Society of New Jersey; and be it further

RESOLVED, that this Resolution be spread upon the minutes of this meeting, and that a copy, suitably prepared, be presented to his bereaved family in token of our heartfelt grief at his passing.

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

Joseph W. Fleisher, M.D., Hudson
Chairman
Peter L. DeLotto, M.D., Morris
J. James Pegues, M.D., Burlington
Bernard A. Rineberg, M.D., Middlesex
Robert L. Wegryn, M.D., Union
Christopher T. Reilly, M.D., Bergen
Alternate Member

Reports:
Committee on Revision of
Constitution and Bylaws
Amendments to Bylaws
Resolution #20

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., Chairman, Morristown

(Reference Committee on Constitution and Bylaws)

PROPOSED AMENDMENTS TO THE BYLAWS

Bylaws
Chapter X—Finance
Section 3—Annual Budget

Current	Proposed		
(a) No officer or committee may spend more money than the amount allowed in the budget. The Board of Trustees may, however, apportion to any officer or committee, on application, any unexpended balance from other items, provided that the total annual budget voted by the House of Delegates is not thereby exceeded.	<i>The Board of Trustees shall have the power to authorize the expenditure of funds in excess of intra-budgetary appropriations as long as budgetary expenditures do not exceed the total adopted budget.</i>	He shall attend all annual or special meetings of this Society and all sessions of its House of Delegates; and he shall keep proper records thereof.	Same
(b) The Board of Trustees shall have the power to authorize the expenditure of funds in excess of budgetary appropriations in accordance with these Bylaws.	Delete	He shall issue official notice of all meetings, annual or special, of this Society or of its House of Delegates.	Same
		He shall notify honorary members of their election.	Same
		He shall require and receive from the secretaries of the component societies, a list of their representatives in the House of Delegates and on the Nominating Committee, and shall publish such lists as the House of Delegates or Board of Trustees may direct.	Same
		He shall require and receive from the secretaries of the component societies, a list of their officers immediately following election, and a list of their committee chairmen.	<i>He shall require and receive from the secretaries of the component societies, a list of their officers immediately following their election.</i>
		He shall be the sole custodian of the official Seal of this Society and shall affix it to such documents as the Bylaws may require, or the House of Delegates, the Board of Trustees, or the President may direct.	Same
		He shall conduct such formal official correspondence in the corporate name of this Society as the House of Delegates, the Board of Trustees, or the President may direct.	Same
		He shall submit to the House of Delegates an annual report of	Same

Approved—Bylaw amendment was adopted.

Bylaws
Chapter V—Officers

Section 3—Rights and Duties of Officers

Current	Proposed		
(c) The Secretary			
The Secretary shall be the official custodian of the Constitu-	Same		

the work of his office.

He shall furnish to the Board of Trustees or the President such information as may be necessary for this Society's business. Same

He shall perform such other functions as are specified in the Constitution and Bylaws. Same

He shall be entitled to reimbursement for expenses incurred in fulfillment of duties imposed by the Bylaws, or authorized by the House of Delegates, or the Board of Trustees. Same

This proposal would relieve the county societies of the unnecessary requirement of forwarding a list of committee chairmen to the Medical Society of New Jersey.

The Committee on Revision of Constitution and Bylaws recommends adoption of this proposal.

Approved—Bylaw amendment was adopted.

Bylaws

Chapter XI—Component Societies

Section 2—Qualification of Members

Current

Proposed

(a) Component societies shall have the responsibility to judge the qualifications of an applicant for any type of membership and alone shall have the power to elect him, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society. Same

(b) To be eligible for membership, the applicant must: Same

1. Be fully licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners;

2. Be legally registered under that license in a county of New Jersey;

3. Be of good moral and ethical standing; and

4. Not support, or practice or claim to practice any exclusive system of medicine.

(c) When a physician applies to a component society for membership in any category, or for membership by transfer from another state, the secretary of the component society shall forward the name and address of the applicant to the physician biographic records department of the American Same

Medical Association for such information as may be on file relative to the applicant's record.

(d) All records of formal actions concerning new and transfer members shall be compiled on forms to be supplied by the Committee on Credentials. Same

(e) In order to retain active membership in this Society the member must hold a current Certificate in Continuing Medical Education from the Medical Society of New Jersey's Committee on Medical Education. This Certificate will be bestowed upon members who complete acceptable programs of continuing education for a total of 150 hours in a given three-year period. This program is to be administered by the Committee on Medical Education in accordance with policy approved by the Board of Trustees and affirmed by the House of Delegates. The Committee on Medical Education may, with the approval of the Board of Trustees, and for good cause, shown, grant specific exemptions to this subsection. Same

~~(f) All active members must retain current active membership in the American Medical Association.~~

This proposal to require AMA membership has been prepared as directed by the 1980 House of Delegates and is herewith submitted for action.

Disapproved—Bylaw amendment was not adopted.

Bylaws

Chapter X—Finance

Section 1—Annual Assessment (Dues)

Current

Proposed

(a) By the first day of January in each year, each component society shall be officially informed of the per capita assessment levied by the House of Delegates. Payment of this assessment shall be forwarded to the Treasurer of this Society not later than five (5) days before the first of March, together with a list of the members for whom such payment is made. Same

(b) Per capita assessments shall apply in the same manner immediately upon the admission or reinstatement of members, except that for a member entering the first year of post-resi-

dency practice the Medical Society of New Jersey dues shall be fifty percent (50%) of regular dues. For a new member admitted after September first of any calendar year, only one-half (1/2) of the regular per capita assessment shall be levied. Every member for whom the per capita assessment is paid shall be entitled to receive such publications as may be issued by this Society for its members.

(c) If a member has not paid his annual assessment by June first, his name shall be dropped from the membership rolls.

(d) The annual assessment of a component society shall not be less than the per capita assessment of at least ten (10) members, the smallest number to whom a charter may be granted to form a component society.

(e) This assessment shall not be levied against any member in good standing if:

1. He shall have attained the age of seventy (70) years; or

2. He is serving with the armed forces of the United States; or

3. He is a member emeritus; or

4. The payment of the assessment would be a financial hardship by reason of physical disability or illness. A member also may be excused from payment of the assessment because of financial hardship for other reasons, but these reasons must be set forth annually by the secretary of the member's component society.

This proposal codifies the current interpretation to the existing bylaws.

The Committee on Revision of Constitution and Bylaws recommends adoption of this proposal.

Approved—Bylaw amendment was adopted.

Bylaws
Chapter V—Officers

Section 3—Rights and Duties of Officers

Current	Proposed
(f) Resignation or Removal	(f) Resignation or Removal
Any officer of this Society may resign. He may be removed from office by action of the House of Delegates, if found guilty by that body of neglect of	Same

duty, improper conduct, or violation of the Constitution and Bylaws. A two-thirds (2/3) vote of the delegates present and voting shall be required to effect such removal.

Any officer, committee member, council member, or anyone holding an elective or appointive position within the Medical Society of New Jersey may be removed by the Board of Trustees for good cause at any time the House of Delegates is not in session.

Same

A two-thirds (2/3) vote of the Trustees present and voting shall be necessary to effect such removal.

Same

Any officer, committee member, council member, or elective or appointive official removed by the Board of Trustees under the foregoing section may file written appeal to the Judicial Council within 15 days of removal. The Judicial Council shall conduct an appeal hearing within 20 days of receipt of such written request. The decision of the Judicial Council shall be final.

The 1980 House of Delegates had requested the development of an appeal mechanism for individuals removed from their positions for cause by the Board of Trustees.

The Committee on Revision of Constitution and Bylaws recommends adoption of this proposal.

Approved—Bylaw amendment was adopted.

Bylaws
Chapter IX—Administrative Councils and Committees
Section 2—Qualifications, Selections and Terms of Members

Current	Proposed
(a) Only regular members of the Medical Society of New Jersey may serve on an administrative council or committee.	(a) Only regular members of the Medical Society of New Jersey may serve on an administrative council or committee, except that one member of the Auxiliary may be appointed by the President to serve on each of the administrative councils and committees for a one-year term.
(b) Reference committee members shall be appointed by the President and must be members of the House of Delegates elected by their respective component societies.	Same
(c) The President shall designate the chairman and vice-chairman of each administrative council and the various committees. The President shall be an ex-officio member of all administrative councils and committees except the Nomi-	Same

nating Committee and the Judicial Committee.

(d) Unless otherwise stipulated in these Bylaws or in the action creating a special committee, the term of service thereon shall be limited to three (3), three-year terms. Interim appointments and unexpired terms are not to be computed in determining the tenure of any member.

Same

(e) Members of councils and committees who have failed to

Same

discharge their duties in a satisfactory fashion maybe removed by the Board of Trustees and the President may fill the resulting vacancy.

The proposal would allow the President to appoint Auxiliary members to administrative councils and committees.

The Committee on Revision of Constitution and Bylaws recommends adoption of this proposal.

Approved—Bylaw amendment was adopted. The intent of the amendment is to allow the Auxiliary members to be full voting members of the respective councils and committees.

Resolution

#20

Introduced by: **Essex County Medical Society**

Subject: **MANDATORY MEMBERSHIP IN THE AMA**

Referred to: **Reference Committee on Constitution and Bylaws**

Whereas, the American Medical Association urgently needs a substantial increase in membership, for many important reasons; and

Whereas, every physician who belongs to organized medicine is in complete agreement that all practical means must be taken to obtain this objective of increasing the AMA's membership; and

Whereas, various means have been proposed for reaching this objective; and

Whereas, there is overwhelming concern on the part of many component societies that one of the proposed means will actually prevent achieving this objective; and

Whereas, the proposal for mandatory membership in the AMA (also referred to as unified billing) was voted in the affirmative by the 1980 House of Delegates out of respect for the AMA officials present; and

Whereas, past history clearly indicates that to establish a compulsory membership in an otherwise voluntary professional organization has caused immediate mass resignations, with the resulting sharp decline in membership; and

Whereas, "freedom of choice" is cherished as much by physicians as by patients; and

Whereas, to make membership in the AMA mandatory will be counterproductive to the goal of increasing its membership, and actually will lose current members of the state and county societies, 11 percent of whom have indicated that they promptly will resign from all three organizations; now therefore be it

~~RESOLVED~~, that the 1981 House of Delegates of the Medical Society of New Jersey promptly reject the proposal to make membership in the AMA mandatory for every member of the Medical Society of New Jersey and of its component medical societies; and be it further

~~RESOLVED~~, that the 1981 House of Delegates direct the Board of Trustees of the Medical Society of New Jersey to pursue every other means of increasing membership in the AMA through the activities of its regular committees.

Adopted as amended by the House by deletion of the first resolved.

REFERENCE COMMITTEE "A"

Francis X. Keeley, M.D., Camden
Chairman

Harry W. Fullerton, Jr., M.D., Salem

Paul J. Hirsch, M.D., Somerset

Jon Marsicano, M.D., Salem

George A. Zazanis, M.D., Morris

Anthony P. Caggiano, Jr., M.D., Essex

Alternate Member

Reports:

President

Board of Trustees

Secretary

Judicial Council

Executive Director

Committee on Credentials

Committee on Long Range

Planning and Development

**Resolutions # 5, # 7, # 12, # 13, # 22, # 23,
24, # 37, # 38E, # 40E**

President

Augustus L. Baker, Jr., M.D., Dover

(Reference Committee "A")

This has been an active and interesting year for me, and I have highlighted in this report major areas of concern.

MEDICAID EXPERIMENT

The Medicaid program never has achieved the purposes for which it was intended. Inadequate financing, poor management perspective, and misguided and over-regulated controls have effected a steady attrition of physicians. There is, however, a basis for optimism. After years of discussion and pressure from the Medical Society of New Jersey, the Division of Medical Assistance has agreed to conduct a pilot project, wherein primary care physicians in two counties will provide services on a 24-hour basis and will be compensated at the UCR level. Atlantic and Mercer Counties have been selected for this study. The Medical Society of New Jersey and the New Jersey Hospital Association are fully supportive of this effort and are urging local hospitals and doctors to maximize their participation. The goal is to divert the patients from the emergency room and outpatient areas of hospitals and provide them with mainstream ambulatory care in the doctor's office. It is anticipated that a significant cost saving will be realized since the physician's office is the most cost-effective delivery site.

PROFESSIONAL LIABILITY—THE DOCTOR AND HIS ATTITUDE—LOSS PREVENTION—INCREASE IN FREQUENCY—SEVERITY

The difficulty of professional liability is still with us. Since 1977 most of us have been insured by the Medical Inter-Insurance Exchange. As a result, we have seen the data firsthand and we cannot deny the proofs. The physician and his attitude are the hub of the problem. We are observing an increase in severity and frequency.

Our risk management program, offered through the Department of Liability control, is innovative and offers high-quality material. It is, however, underutilized by the membership of this Society.

I am convinced that we can reach the ultimate solution only after we admit to honest problem definition. As long as we keep diverting our energy to legislative matters and litigation tactics, we will not address the major issue—the physician—his actions—reactions—and perceived demeanor. This is in conformity with my inaugural speech,

wherein I indicated that maintaining the image of the medical profession is the individual responsibility of each physician.

STATE BOARD

It is difficult at this point for me to declare exactly where we are in our relationship to the State Board of Medical Examiners.

Over the last several years, the administrative hearing process has caused a severe reaction among the profession. We have addressed this situation with the Legal Services Plan which has been so well received by our membership.

The Society is cooperating with the State Board in the development of excessive fee regulations. We also continue to monitor and comment on the development of other regulations regarding medical practice. I am optimistic that the voice of the profession will be respected by the State Board of Medical Examiners.

REGIONALIZATION—DRG—PR PROGRAM RESULTS—PUBLIC RESPONSE

The DRG program has continued to be a major issue. In accordance with the position adopted by the House of Delegates, the Society directed a major effort at public education. The results of this campaign have been rewarding, with significant public response. Members of the Board have participated in public debates, and have advanced our position.

The perinatal regionalization plan has developed into a major public issue. Press coverage has been extensive and legislative interest is keen. The Medical Society of New Jersey's position has been articulated fully in the press and before the legislative and executive branches of the state government. Bills have been introduced on this topic and have been discussed in the legislature with testimony being presented by the Medical Society of New Jersey.

CHARTER—ASSEMBLY BILL

The charter changes necessary to provide for specialty and student representation are passed in the Senate and were voted out of committee in the Assembly. We are hopeful that final action will be taken prior to the Medical Society of New Jersey's Annual Meeting.

CHANGE IN SIZE OF HOUSE (DUES-PAYING MEMBERS)

The Board of Trustees and the Special Committee on Long Range Planning and Development again have reviewed the question of reducing the size of the House of Delegates to produce a more efficient deliberative body. An independent study by management consultants recommended an elected House with 100 representatives. The Committee on Long Range Planning and Development has recommended a reduction to "no more than 300 elected delegates." I personally favor a smaller House and believe 300 elected representatives would more than assure grass roots representation, while at the same time moving toward a more efficient mechanism. This, of course, can be quite a controversial topic, mainly because most members of the House feel they are voting themselves out of office. However, there are many absentees at each session and, presumably, these would be the ones to be deleted.

Perhaps there is another way to address this problem. Our base of dues-paying membership continues to decline while overall membership increases. My suggestion is that elected representation in the House should be based purely on the premise of dues-paying members, and that only dues-paying members could serve as delegates or alternates. In that fashion, only those paying the bills would have a voice in policy. I do not fear that they would not treat the dues-exempt members with kindness and consideration since medicine is a respected and respectful learned profession.

HOSPITAL BYLAWS—MEDICAL SOCIETY OF NEW JERSEY MEMBERSHIP AS A REQUIREMENT FOR STAFF PRIVILEGES

The major point of interest for most physicians is the hospital medical staff. Medical Society membership as a requirement for obtaining and retaining staff privileges is a valid and enforceable requirement which should be seriously reconsidered. The benefits to the Society are obvious. There are, however, significant benefits to be realized by the hospital and the patients it serves. The major ones are listed below:

- a. The continuing medical education requirement;
- b. Adherence to and enforcement of the Principles of

Medical Ethics;

c. Participation in and submittal to the scrutiny of peer review and cost effectiveness; and

d. Participation in the activities of the Department of Liability Control and the advantages of risk-management programs.

All of the above produce an aware and more competent physician, attuned to the mainstream of medical practice. It also should be emphasized that in regard to professional liability litigation this Society, through its members, participates in the Supreme Court Rule 4:21 program which has been recognized by New Jersey's Assignment Judges as a major advance in the prompt administration of justice.

Thus, it is clear to me, and I believe to anyone who takes an objective look, that a requirement of Society membership properly drawn and fairly administered would be viewed as a reasonable and enforceable requirement by an enlightened judiciary.

ASAE REPORT

This report has been studied thoroughly by several groups within the Society. I believe that the role of the President should not be altered from its present status regarding presiding at meetings of the Board of Trustees and the House of Delegates. As a matter of fact, I find it beneficial not to be burdened with the administrative detail of the Chairman of the Board and the Speaker of the House of Delegates, and consequently am able to speak my mind freely in policy matters and development.

I believe a change in the office of the President is not indicated. The staff provides the needed continuity through the years, and a *practicing* President brings the perspective of those of us who are on the firing line and thus the essence of this Society.

I cannot close this report without expressing my gratitude to the Officers and Trustees of this Society, who, along with the members of the various councils and committees, gave their time and effort so generously on behalf of the doctors of New Jersey. This is your Society—use it, enjoy it, keep it well!

Filed in accordance with the recommendation of the Reference Committee.

Board of Trustees

William Greifinger, M.D., Chairman, Belleville

(Reference Committee "A")

I am privileged to report on the activities of the Board of Trustees during the past year. *Progress* is the key word. You can be proud of your elected Officers and Trustees for they have attended meetings faithfully and all have served on important committees and administrative councils.

Attendance of county society and specialty society officers has improved and in association with AMA delegates, student representatives and the leadership of the College of Medicine and Dentistry of New Jersey and New Jersey Hospital Association, there has developed a fuller under-

standing of problems and issues. Many of the latter are complex but with comprehensive study and debate, resolution results. Certainly, the skilled and dedicated administrative staff eases our burdens, and for this we are grateful.

Some of the major issues are listed herein, hopefully concisely and clearly. The actions of our Board are not always unanimous, but expectedly not. We all don't think alike but I am confident the interests of our patients and the community have been served and will continue to be served.

Our Medical Society is the umbrella for all of us, special-

ists and family physicians alike. Hopefully fair, we act and react for the majority, as it should be. Even though Thoreau wrote that, "If a person thinks he is in the right, he is then a majority of one . . ." in our true democracy, the final vote is what counts.

For those of you who are eligible but have not attended our Trustee meetings, I urge you to do so. Annual meetings are just that—annual. Much needs to be done in the interval.

Filed in accordance with the recommendation of the Reference Committee.

AMA POLICY ON PHYSICIANS' ASSISTANTS

(Reference Committee "A")

The AMA House of Delegates in 1979 adopted a resolution introduced by New Jersey which called for study and reevaluation of the Association's position on physicians' assistants. A task force representing the Council on Medical Service, the Council on Medical Education, and the Council on Legislation was established to develop recommendations on this subject for transmittal, as a joint report of the respective Councils, through the Board of Trustees, to the House of Delegates.

During the 1980 AMA Interim Meeting, the House of Delegates adopted as amended the Joint Report which evaluates the AMA's policy on physicians' assistants (PAs), opposes increased public funding for PAs training programs, urges that PAs be authorized to provide care only under the supervision of a physician, and opposes giving PAs the authority to prescribe independently.

On the state level efforts to enact physicians' assistant legislation failed on two occasions.

Filed in accordance with the recommendation of the Reference Committee.

FALL AND SPRING CONFERENCES

(Reference Committee "A")

In November, the Board hosted a conference for over 60 participants representing component and specialty societies and hospital chiefs of staff. The program featured an update on professional liability, national medical issues and an open session with the Board of Trustees. Another program is planned for early spring.

Filed in accordance with the recommendation of the Reference Committee.

LEGAL SERVICES PLAN

(Reference Committee "A")

As of December 15, 3,400 members were enrolled in the Legal Services Plan endorsed by the Medical Society of New Jersey.

The Plan provides consultation by the law offices of Steven

I. Kern, Esq., to any participating physician who receives an inquiry from the State Board of Medical Examiners. The consultation includes a total review of the participating physician's actions which are the subject of the Board's inquiry, discussion with the physician with regard to the appropriate response to the Board, and assistance in the drafting of any written response required by the Board. In the event the physician is required to appear before the Board, Mr. Kern personally will accompany the physician and provide representation.

At the present time, thirty-seven of the Plan members received inquiries from the State Board of Medical Examiners. Seventeen of these have resulted in a hearing appearance; six involved dealings with investigators; and fourteen required a written response. Twenty of these cases have been resolved with the following results: 15—no cause for action; 1—letter of reprimand; and 4—payment of fine, but no suspension or revocation of license. There are still seventeen cases pending. It is estimated that at least two of these may result in a formal complaint.

Filed in accordance with the recommendation of the Reference Committee.

NATIONAL HEALTH INSURANCE

(Reference Committee "A")

New Jersey introduced a resolution at the 1980 Annual Meeting of the AMA which called on the organization to continue to oppose any federally controlled or administered national health insurance plan and also proposed that the AMA adopt the position that any modifications of the health insurance system embody certain enumerated principles.

The AMA Board of Trustees and its Councils on Legislation and Medical Service currently are undertaking a thorough review of factors affecting health insurance legislation stemming from the recent national elections and will report to the House at the 1981 Annual Meeting.

Filed in accordance with the recommendation of the Reference Committee.

WRITING OF ORDERS AND PRESCRIPTIONS BY MEDICAL STUDENTS

(Reference Committee "A")

The State Board of Medical Examiners had reaffirmed its previous position of opposition to the writing of orders and prescriptions by medical students and determined that there was no current legislative authority that would permit medical students to write such orders, as only interns and residents are exempt from the licensing provision of the statutes in accordance with 45:9-21(D).

Filed in accordance with the recommendation of the Reference Committee.

Secretary

Arthur Bernstein, M.D., Millburn

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, minutes of Board of Trustees' meetings, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or adviser.

MEMBERSHIP

(as of December 31, 1980)

Active:	Paid	7,706	
	Exempt	914	8,620***
*Associate:	Paid		0
**Affiliate:	Paid		81
	Exempt		3
State Emeritus		616	
Total of Above		9,320	
State Honorary		8	
New and Reinstated Members:			
Active		400	
Change of Status		12	
Transfers within the state		35	
Transfers out-of-state and resignations		82	
Members deceased		131	
Members dropped:			
Active (non-payment of dues)		99	
(N.J. licensure revoked)		1	
(N.J. licensure suspended)		4	
(N.J. licensure surrendered)		1	105

*Associate membership (non-licensed in N.J.) designates Interns and Residents.

**Affiliate membership-physicians who no longer practice in New Jersey.

***Adjusted for transfers out-of-state, resignations, and deaths.

AMA MEMBERSHIP

A total of 6,282 members of the Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates stands at seven delegates—one for each thousand members, or fraction thereof.

MEMBERSHIP DIRECTORY

The 1981 *Membership Directory* was completed in February 1981. Distribution was made to the entire membership during the month of March. For those members who wish a second copy of the 1981 *Membership Directory* it is available for a fee.

I would like to take this opportunity to express my sincere gratitude to the membership for their prompt response to the questionnaire which was mailed to them. This enabled staff to reduce considerably the amount of time necessary for production and also gave us a more current *Membership Directory*.

Filed in accordance with the recommendation of the Reference Committee.

Judicial Council

Albert F. Moriconi, M.D., Chairman, Trenton

(Reference Committee "A")

From official records the Judicial Council here presents a summary of its operations and those of county judicial committees for the period May 11, 1980 to March 1, 1981.

By Judicial Committees

Complaints reported as disposed of	42
Alleging:	
Dissatisfaction concerning fees	20
Unprofessional conduct	7
Dissatisfaction concerning medical procedures	7
Dissatisfaction concerning professional ethics	8

By Judicial Council

Meetings Held	4
Official communications acted upon	53
Appeal hearings requested	6
Appeal hearings granted	0
Formal opinions rendered	3

ETHICAL PROCEDURES IN SECOND SURGICAL OPINIONS

(Officially adopted January 23, 1980)

The 1980 House of Delegates requested the Judicial Council to reconsider *Opinion No. 27, Ethical Procedures in Second Surgical Opinions*. Reference Committee "A" felt that a section placing an obligation of notice on the second surgeon, when being chosen to perform the surgery, should be revised with the patient assuming such responsibility.

The Chairman of the Judicial Council advises the House that queries referring to this subject have been thoroughly investigated concerning mandatory and elective second opinion programs. The Council unanimously agreed that a patient's obligation to advise the initial surgeon could not be legislated and that the second surgeon, therefore, would have the ethical obligation of notifying that surgeon that he would be performing the surgery at the patient's request. In view of the foregoing, the Council reaffirms *Opinion #27*.

Opinion #27—

Several concerns have been expressed to the Judicial Council by the Judicial Committee of the Union County Medical Society in regard to second surgical opinion programs.

The first issue involves the propriety of the second physician advising that surgery is necessary and then performing that surgery at the request of the patient.

Assuming that the second surgeon has not acted improperly or exerted undue influence, the Council finds that there are no absolute barriers to prevent the second surgeon from performing the surgery. Freedom of choice of the patient along with trust implicit in the physician-patient relationship are controlling factors. The second surgeon does, however, have an ethical obligation to notify the referring surgeon that he will be performing the surgery at the patient's request.

The next issue involves the situation where the second physician, by attitude or conversation, implies that he is better qualified than the initial physician or that the patient has thus far not been properly treated.

The Council finds that such conduct would be the patent solicitation of patients, which is clearly unethical and potentially violates N.J.A.C. 13:35-6.13 which prohibits solicitation of patients and claims of professional superiority.

CREDIT BUREAU SOLICITATION

Officially adopted September 24, 1980 as MSNJ Opinion #28)

Opinion No. 28 is presented in full as follows:

A request for an opinion was received from the Bergen County Medical Society concerning a credit bureau reporting service solicitation of physician accounts.

The service would make data available to subscribers from its bank in conformity with Public Law 91-508. Physicians would be obligated to direct data into the bank as would any other participant.

The Council does not believe that this type of service is readily adaptable to medical practice. This matter is one of first impression and does not appear to violate any of the existing principles of medical ethics.

If physicians wish to utilize such a service they may do so provided they notify their patients of this practice.

The Council believes this type of commercial activity may prove to be inappropriate and may tend to lower ethical standards.

We are reserving the right to review this situation once some practical experience has been gathered.

JURISDICTION OF FEE REVIEW CASES

(Officially Adopted January 21, 1981 as MSNJ Opinion #29)

Opinion No. 29 is presented in full as follows:

A number of inquiries have been received by the Judicial Council regarding the appropriateness of establishing "Fee Review Committees."

The Judicial Council requested Legal Counsel to advise us in this regard since there are questions related to antitrust and the Federal Trade Commission.

Legal Counsel has advised that questions and complaints regarding fees are specifically within the jurisdiction of the judicial mechanism of the Medical Society of New Jersey and the judicial committees of the component societies and should be treated accordingly as questions of ethics and professional conduct.

County society judicial committees should conduct themselves accordingly. They may, of course, utilize the opinions of specialists or advisory committees in reaching their determinations.

REGULATIONS

The Council at this time would like to point out to the chairmen of the judicial committees of the component societies a primary cause of appeals during the past several years.

The *Rules and Regulations* of the Judicial Council provide that when efforts for amicable settlements of complaints have failed, a hearing must be held, to which all parties are invited, before the complaint can be disposed of at the county level.

All too frequently the Council receives requests for appeal hearings wherein the record reveals that after settlement efforts have failed, the judicial committee reached a final decision without the benefit of a hearing. The Council has been constrained in these instances to refer these cases back to the judicial committee with the directive to hold a hearing.

The Council urges that each county committee strive to improve its procedure in this regard. Therefore, the committees again are reminded to follow the directions contained and the procedural steps outlined in the *Rules and Regulations for the Processing of Grievances and Complaints*.

Only by means of a full understanding and observance of the *Regulations* can the judicial committees together with the Judicial Council succeed in functioning at the level of adequacy intended by MSNJ's House of Delegates.

EXCESSIVE FEES FOR PROFESSIONAL SERVICES (N.J.A.C. 13:35-6.15)

The Medical Society of New Jersey agrees with the intent of the proposed State Board of Medical Examiners' Regulation which aims to adjudicate excessive fee complaints against physicians and other practitioners.

The Board of Trustees of the Medical Society of New Jersey approved a proposal for submission to the State Board of Medical Examiners that would enable them to utilize MSNJ's judicial mechanism. The administration of this system would be by the Medical Society of New Jersey and the county medical societies with a final appeal to the State Board of Medical Examiners.

The Medical Society of New Jersey believes its judicial mechanism would provide a valuable service to the New Jersey State Board of Medical Examiners' implementation of N.J.A.C. 13:35-6.15.

The State Board of Medical Examiners has not yet indicated whether it will incorporate the Medical Society of New Jersey's structure in its program.

Filed in accordance with the recommendation of the Reference Committee.

Executive Director

Vincent A. Maressa, Lawrenceville

(Reference Committee "A")

Pursuant to a request from the House, the Board of Trustees has developed a reinstatement policy for dues-delinquent members. That policy calls for a \$50 fee if reinstated between June 1 and December 31, and a full year's dues plus current dues if reinstatement occurs in a subsequent calendar year.

The dues-delinquent member is a major problem. He/she consumes services without paying for them. The end result is that the regular paying members must face the prospect of being assessed higher dues to accommodate these individuals. A review of membership data will illustrate this problem.

On December 31, 1979, there were 7,803 paid members in the Society. By May 1980, we had a "book count" of 7,935 paid members but the Medical Society of New Jersey had not received 1980 dues for that number. Consequently, on June 1, 1980, the delinquent memberships were terminated. The 651 members whose memberships were thus terminated consumed services and staff time from January 1, 1980, through May 31, 1980. Then, after June 1, 1980, more time and services were spent attempting to reinstate these members. By December 31, 1980, we had recovered 91 of these physicians but without payment of any added fee. The House must decide whether it wishes to continue to encourage this activity.

In this fashion, the ratio of dues-exempt and emeritus members to dues-paying members is producing an unhealthy trend. Our total membership on December 31, 1980, was 9,320. Of that total 1,530 were either dues exempt or emeritus and thus eligible for all Society services and programs. This represents an increase of 104 such members over the December 31, 1979, number. At the same time, between December 31, 1979, and December 31, 1980, the paid membership

dropped from 7,803 to 7,706. I don't think further elaboration is necessary.

Solutions are not easy to develop. While a concerted membership drive is easy to talk about, it is not easy to achieve. Further, the available pool of eligible non-members is not really large enough to justify the expense involved. It does not greatly exceed the number of dues delinquents that we encounter each year. Medicaid records reveal about 6,700 billing physicians while Medicare shows nine to ten thousand. Professional liability insurers indicate about 9,300 active insureds. If 1,000 of these are subtracted as representing a combination of osteopathic physicians and moonlighting residents, the remaining 8,300 are only 600 over our December 31, 1980, paid membership. Beyond that, data on the non-member, especially an accurate address, are difficult to secure.

We could, of course, curtail services and reduce staff. We could increase non-dues areas of income. In pursuing this latter course, however, it must be acknowledged that what we have to market for the most part is information and access to our membership. A number of members may not approve of this approach. The staff has these and other possibilities under study and will submit them to the Board as they are developed.

It always is encouraging to have the membership respond convincingly to our programs. In closing this report, I am pleased to announce that the Legal Services Plan, instituted by Board action in April 1980, now has 4,000 enrolled members.

Filed in accordance with the recommendation of the Reference Committee.

Credentials

Arthur Bernstein, M.D., Chairman, Millburn

(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the Committee's activities during the period March 1, 1980 to February 28, 1981.

	*Associate	Active	Osteopaths	Grand Total
Received:				
*Interns	0			
*Residents	<u>4</u>			
Grand Total	<u>4</u>	<u>300</u>	<u>11</u>	<u>315</u>
Reviewed and found:				
(A) Satisfactory				
*Interns	0			
*Residents	<u>4</u>			
Sub Total	<u>4</u>	268	11	283
(B) Unsatisfactory	0	0	0	0
Pending:				
*Interns	0			
*Residents	<u>0</u>			
	0	20	0	20

Withdrew:				
*Interns	0			
*Residents	<u>0</u>			
Grand Total	<u>4</u>	<u>12</u>	<u>0</u>	<u>12</u>
		<u>300</u>	<u>11</u>	<u>315</u>
*Associate membership (non-licensed in New Jersey) designates Interns and Residents.				

The Committee extends appreciation to the directors and the secretaries of component societies, and to those who assist them, as well as the county credentials committees, for their cooperation in processing membership applications. It would be especially helpful to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials. The chairman wishes to thank his Committee members and MSNJ staff for their diligence and cooperation.

Filed in accordance with the recommendation of the Reference Committee.

Long Range Planning and Development

William J. D'Elia, M.D., Chairman, Spring Lake

(Reference Committee "A")

MSNJ AUXILIARY

As mandated by the 1980 House of Delegates, the Committee proceeded with the task of reevaluating the functions of the Advisory Committee to the Auxiliary. Our report was sent to the Board and approved by them. One of the renovations is to make possible Auxiliary representation on councils and committees of the Medical Society of New Jersey. This will be decided by the House via the report of the Committee on Revision of Constitution and Bylaws.

ASAE EVALUATION REPORT

The Committee devoted several meetings to this topic. We considered not only the report itself but staff response and Board comment. The following items have been accepted by the Board and the Committee on Long Range Planning and Development:

1. That the Board of Trustees charge itself and all councils and committees with the task of developing a yearly list of specific goals and objectives, and conducting a periodic review of their progress.
2. The Society should consider giving more emphasis to its Committee on Long Range Planning and Development and to setting specific long-range goals to extend the short-term priorities recommended in the paragraph above. These long-range goals should be stated clearly to the House of Delegates and the Board of Trustees as well as communicated

directly to the membership for its input and comment. In addition, in setting long-range goals, the Society should communicate with community leaders to determine directions for the development of new services and greater communications.

3. In order to achieve greater delineation of short-term and long-term goals and objectives that meet the specific needs of the members, the evaluation team recommends that the Medical Society of New Jersey undertake an in-depth membership survey to review the impact of its present efforts and to pinpoint changing conditions in the field of medicine to which the Society should respond. A draft of such a survey can be developed by the headquarters office and then given to the Long Range Planning Committee for evaluation and review.

The evaluation committee feels that detailed input of this sort is particularly important in light of the changing impact from patients, the State Legislature and the community on physicians and the implementation of health care.

4. That the Nominating Committee be directed to evaluate objectively the candidates for leadership positions in the Society from the standpoint of ability, leadership capabilities, past performances, and effective actions.

5. The evaluation team was concerned about the large number of committee meetings held during the course of the

year and felt that some of the time spent in these meetings could be reduced by having a considerable amount of the activities handled by mail and telephone, as well as by having the headquarters office become more involved in implementing activities while the committees set policy. The headquarters office is set up to provide excellent liaison with committees, and the elected leadership would do well to make better use of the abilities which the state office offers for implementing activities. A clear-cut delineation of having committees set policies and the headquarters office implement them would tighten up the amount of time the very busy elected leadership would need to spend on these activities.

6. As one mechanism for providing a more effective use of elected leaderships' time, the evaluation team recommends that an orientation program be developed for the Board of Trustees and the committees at the start of each year. Such a program could assist elected leadership in setting goals and policies and in maximizing their talent and use of time.

7. The evaluation team was concerned that the structure of the Society does not allow greater direct input on the part of the membership. For example, members of the House of Delegates are selected by the county medical society governing bodies, officers are elected by the House of Delegates, and committee members are selected by officers. Thus, it is difficult for the average member to have any impact on the governing structure of the organization. The evaluation team recommends that the selection of elected leadership be re-evaluated by the Long Range Planning Committee in order to make it possible for the membership of the organization to have more input into the selection of its officers, directors, and committee chairmen. While the logic of selecting members of the House of Delegates from the county medical society is clear, the evaluation team recommends that the officers of the organization be elected by mail ballot by the membership after a slate of officers is selected by the Nominating Committee. In addition, the team recommends that the membership be given more input into the nominations process than it presently has.

8. The evaluation team recommends that staff consider developing a "Board policy manual," which lists policy decisions made by the Board of Trustees and the House of Delegates over the past five years. Such a manual would assist the Society in understanding its present policies and defining which activities most adequately could be handled by which governing bodies within the organization. The manual would help assure that the working operation of the Society is most effective.

9. The evaluation team recommends that the size of the House of Delegates be reduced to a maximum of 100 individuals, selected as members presently are, by the county medical societies on the basis of membership representation from each geographical area.

The reapportionment of the House of Delegates formerly was considered by the Committee on Long Range Planning and Development and, in an attempt to achieve a more effective meeting of the House, a recommendation was made to reduce the number of elected delegates, which was approved by the Board of Trustees. The recommendation was not adopted by the 1980 House of Delegates.

The concept of limiting the size of the House to 300, based on a ratio of one delegate per 31 members, with the proviso that each component society be entitled to at least three delegates, was reconsidered and the determination was reached to resubmit the recommendation made by the

Committee last year.

Two major disadvantages with the current number of delegates were observed: (a) the inability to change the format of the Annual Meeting; and (b) the difficulty in locating a single facility in New Jersey to accommodate the activities of the Annual Meeting.

In addition to reducing the size of the House, the Committee also suggested that efforts be made to limit discussion in the House to qualitative issues, to achieve an efficient utilization of people and time.

10. That guidelines be established to govern the scope of topics to be considered by the House.

11. That the evaluation of councils and committees continue to be a function of the Board of Trustees, in conjunction with the staff of the Medical Society of New Jersey.

12. That a survey, qualified to produce a defined result, be conducted to determine whether the membership would be in favor of a mail ballot vote: (a) to elect officers; (b) adopt major policy of the Society; and (c) amend Bylaws.

13. Attendance at the Annual Meeting has been decreasing over the past several years. The evaluation team recommends that the Annual Meeting be scheduled in an attractive location and spouses be encouraged to participate by an active spouse program in an attempt to encourage greater attendance. In addition, it is recommended that management of the meeting be handled on an in-house, full-time basis, and integrated with the other meetings that presently are conducted in the headquarters office, putting the two activities together as they should be will encourage more professional management which should result in greater attendance at the Annual Meeting. The evaluation team feels that the Society should strengthen its liaison with medical schools, hospitals, and specialty societies in an attempt to broaden the scope of its services to the "total house of medicine" with the State of New Jersey. This is especially important in providing the Society with a stronger base from which to attract new physicians into the organization. Moreover, it is important for the field of medicine to show a united front within the state in this time of legislative uncertainties and increasing controls on the part of third-party carriers.

The Committee agreed that this is an ongoing process. Specific instances mentioned were the legislative efforts to effect a Charter change, and the various proposals concerning specialty society representation.

14. It is recommended that the Society establish closer relationships with the medical specialty societies in the State, possibly through regular meetings and through invitations to the representatives of the societies to attend the meetings of the House of Delegates. The lack of response of the American Medical Association to the needs of specialty societies resulted in a significant downturn in AMA membership. Now that specialty societies have been included, the American Medical Association is gaining momentum. The Medical Society of New Jersey might consider, in a phased manner, beginning to include state specialty societies in its operation. The first step would be to invite representatives to meetings of the House of Delegates; the second could be to consider including a representative from each specialty society in the House of Delegates.

This recommendation involves an organizational policy decision to be made by the House of Delegates. The preliminary steps have been taken to effect a determination by the House regarding the concept.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#5

Introduced by: **Board of Trustees**
Subject: **REAPPORTIONMENT OF HOUSE OF DELEGATES**
Referred to: **Reference Committee "A"**

Whereas, several committees of the Medical Society of New Jersey have studied the size of the House of Delegates of MSNJ; and
Whereas, these committees have found that a reduction in the size of the House would facilitate a more efficient, thorough, and comprehensive presentation of issues; now therefore be it

RESOLVED, that the Committee on Revision of Constitution and Bylaws be instructed to prepare amendments to the Bylaws, limiting the number of elected delegates to 300, with each component society entitled to at least three delegates.

Rejected in accordance with the recommendation of the Reference Committee.

#7

Introduced by: **Frank J. Primich, M.D., Delegate Hudson County**
Subject: **REPEAL OF PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO) LEGISLATION**
Referred to: **Reference Committee "A"**

Whereas, the majority of members of MSNJ have objected to the concept of PSROs since its inception; and
Whereas, active participation in the process has been excused as the only alternative to non-medical review; and
Whereas, there is strong pressure in the incumbent Congress to repeal the PSRO legislation; and
Whereas, the AMA is downplaying the 104-100 vote for repeal by its House of Delegates; and
Whereas, many delegates of MSNJ and the AMA have inadvertently conflicting interests regarding continuation of the program; now therefore be it

~~regarding their position on the issue of PSRO repeal; and be it further~~

~~RESOLVED, that the poll results be publicized; and be it further~~

~~RESOLVED, that MSNJ's Delegates to the AMA duly consider the will of the membership of MSNJ in presenting MSNJ's position to the AMA.~~

~~Amended by the Reference Committee by deletion of the three resolves and substitution of the following:~~

~~RESOLVED, that the Medical Society of New Jersey strongly reaffirms the position of the American Medical Association urging the repeal of the PSRO legislation.~~

Adopted as amended by the Reference Committee.

~~RESOLVED, that the membership of MSNJ be polled~~

#12

Introduced by: **Hudson County Medical Society**

Subject: **SIZE OF HOUSE OF DELEGATES**

Referred to: **Reference Committee "A"**

Whereas, a proposal has been made to reduce the size of the House of Delegates; and

Whereas, many delegates perceive attendance at meetings of the House as their only opportunity for input into the affairs of the Medical Society of New Jersey; and

Whereas, the sense of participation at the grassroots level

should be encouraged rather than discouraged; now therefore be it

RESOLVED, that the House of Delegates be maintained at its present size.

Adopted in accordance with the recommendation of the Reference Committee.

#13

Introduced by: **Hudson County Medical Society**

Subject: **SEATING OF ALTERNATE DELEGATES**

Referred to: **Reference Committee "A"**

Whereas, the Bylaws of the Medical Society of New Jersey require that once an elected delegate has yielded his seat to an alternate delegate during any meeting, he no longer can be seated for the remainder of that meeting; and

Whereas, the American Medical Association has no such restriction (AMA Bylaws, section 2.431 . . . "if the delegate is not present, the place may be taken during the . . . absence by an alternate"); and

Whereas, this mechanism allows significant participation by alternate delegates in the working of the American Medical Association House of Delegates; and

Whereas, this participation increases the capability of a delegation by allowing delegates and alternates to concentrate on areas of their expertise and interest; now therefore be it

RESOLVED, that the Medical Society of New Jersey Bylaws be appropriately revised to allow greater participation by alternate delegates in the actions of the House of Delegates without penalizing the delegate for yielding his seat temporarily and thereby being denied seating for the remainder of the meeting.

Referred to the Board of Trustees for implementation. Reference Committee recommendation, which was not adopted by the House, had been for rejection.

#22

Introduced by: **Essex County Medical Society**

Subject: **PHYSICIAN-GUESTS ATTENDING THE THIRD-AND-FOURTH FIRST AND SECOND PARTS OF THE THIRD SESSION-SESSIONS OF THE HOUSE OF DELEGATES**

Referred to: **Reference Committee "A"**

Whereas, the Medical Society of New Jersey for many years has invited physicians who are official representatives, officers, or members of other medical societies—state and national—to attend the annual meeting as guests; and

Whereas, these invited guests have participated in our annual meetings to the mutual advantage of the respective medical societies; and

Whereas, these invited guests are afforded the opportunity to

address the House of Delegates at its first and second sessions (known as the general sessions), at which time they may present their views from the rostrum on mutual problems, or comment on any portion of the agenda; and

Whereas, these invited guests also have the privilege of attending the reference committee meetings, and may address those gatherings to give their opinions for or against the various resolutions; and

Whereas, at the third and fourth sessions of the House only delegates have the privilege of addressing the House to discuss the resolutions, while all other physicians may address the House only through its expressed consent; now therefore be it

~~RESOLVED, that at all future annual meetings or special meetings of the House of Delegates of the Medical Society of New Jersey, no invited guest will be permitted to lobby for or against any resolution by addressing the House from the rostrum during any portion of its third and fourth sessions; and be it further~~

RESOLVED, that it will be the duty of the Speaker of the House to enforce this rule strictly and without exception, regardless of the office or the organization represented, and regardless of any circumstances which might prevent a guest

~~from addressing the House at its general sessions; and be it further~~

~~RESOLVED, that if a guest wishes to speak at the third or fourth sessions of the House, the Speaker must obtain the consent of the House, and the guest will speak from the floor for the same length of time as has been determined for all other participants.~~

~~The change in the subject was ruled editorial by the Speaker.~~

~~Amended by the Reference Committee by deletion of the first two resolveds and rewording the third resolved to read:~~

~~RESOLVED, that if a guest wishes to speak at the first or second part of the third session of the House regarding an issue before the House, the Speaker must obtain the consent of the House, and the guest will speak for the same length of time as has been determined for all other participants.~~

~~Adopted as amended by the Reference Committee.~~

#23

Introduced by: **Ocean County Medical Society**

Subject: **COMPREHENSIVE LEGAL SERVICES PLAN FOR PHYSICIANS**

Referred to: **Reference Committee "A"**

Whereas, physicians in increasing numbers are being required to appear for hearings before the New Jersey State Board of Medical Examiners; and

Whereas, legal representation at such hearings is essential for the physician's protection; and

Whereas, alleged overcharging, alleged hiring of improper personnel and a host of other matters now are considered within the purview of the State Board of Medical Examiners, when formerly only such matters as alleged malpractice, alleged faulty prescription writing, drug and alcohol abuse, and conviction of a felony were considered matters to be reviewed by the State Board of Medical Examiners; and

Whereas, legal representation, as provided by the physician himself, may be inappropriate insofar as the expertise required to appear before a body such as the State Board of Medical Examiners, and also legal representation as provided by the physician himself can become extremely expensive for anyone and even unaffordable for some physicians; and

Whereas, the present insurance coverage with attorney

Steven I. Kern, as approved by the Medical Society of New Jersey, only provides representation up to that point when a formal complaint is lodged and after which the accused physician is "on his own" as regards legal fees; and

Whereas, no practicing physician in the State of New Jersey now can consider himself reasonably safe from being summoned before the State Board of Medical Examiners; and

Whereas, the risk of being censured and/or punished by the State Board of Medical Examiners now has become as much of a risk as having a professional liability action brought against a physician; now therefore be it

RESOLVED, that the Medical Society of New Jersey consider providing a plan which offers comprehensive legal representation for physicians **who are members of the Medical Society of New Jersey** through the conclusion of any complaint by the State Board of Medical Examiners.

Amended by Reference Committee by insertion of the words indicated above.

Adopted as amended by the Reference Committee.

#24

Introduced by: **Ocean County Medical Society**

Subject: **LEGISLATION TO LIMIT THE TERM OF SERVICE ON THE STATE BOARD OF MEDICAL EXAMINERS**

Referred to: **Reference Committee "A"**

Whereas, there is no stipulated term for membership on the New Jersey State Board of Medical Examiners; and

Whereas, it is desirable that the Board be constituted as a continuing body; now therefore be it

~~RESOLVED~~, that no member of the State Board of Medical Examiners ~~serve longer than one five-year term, and, to preserve continuity, the terms of all members should be staggered; and be it further~~

~~RESOLVED~~, that the Medical Society of New Jersey recommend legislation to accomplish the intent of this resolution.

Subject changed to conform to intent.

Reference Committee recommended deletion of the two resolveds and substitution of the following resolved:

RESOLVED, that no member of the State Board of Medical Examiners serve more than two consecutive three-year terms, and, to preserve continuity, the terms of all members should be staggered.

Adopted as amended by the Reference Committee.

#37 (Corrected)*

Introduced by: **Middlesex County Medical Society**

Subject: **EQUAL RIGHTS FOR MEN AND WOMEN**

Referred to: **Reference Committee "A"**

Whereas, the AMA espouses the concept of equality for all individuals regardless of race, religion, age, or sex; and

Whereas, AMA policy supports "equal opportunities for men and women in all phases of medical endeavor and activities"; and

Whereas, the AMA has encouraged the state, county, and specialty societies to take similar positions; and

Whereas, the Bylaws of the AMA have been changed to affirm civil rights; and

Whereas, the recent approval of the AMA Principles of Medical Ethics states, "a physician must recognize responsibility not only to patients, but also to society, to other health

professions, and to self"; and

Whereas, Article VII of said Principles states, "a physician shall recognize a responsibility to participate in activities contributing to an improved community," and at the request of its members; now therefore be it

RESOLVED, that the Medical Society of New Jersey urge the AMA to affirm the concept of equal rights for men and women in all endeavors and activities.

*Corrected to include underscored words.

Amended by the Reference Committee by deletion of the words indicated.

Adopted as amended by the Reference Committee.

#38E

Introduced by: **Middlesex County Medical Society**

Subject: **AMA DEPARTMENT OF NEGOTIATIONS**

Referred to: **Reference Committee "A"**

Whereas, physicians are becoming increasingly involved with governmental, institutional, and sociological problems; and

Whereas, the training of the physician has been deficient in the art of negotiations; and

Whereas, the government, hospital administrators, lawyers, and third-party payers are utilizing personnel trained in the art of negotiations when dealing with physicians; and

Whereas, a skilled negotiator is essential for adequate representation and is an asset to the profession; and

Whereas, a skilled negotiator is an asset to both sides in any dispute; now therefore be it

RESOLVED, that the American Medical Association be encouraged to maintain the Department of Negotiations.

Adopted in accordance with the recommendation of the Reference Committee.

#40E

Introduced by: Charles Harris, M.D., Delegate
Ocean County

Subject: **EXCESSIVE FEE REGULATIONS OF THE STATE BOARD OF
MEDICAL EXAMINERS.**

Referred to: **Reference Committee "A"**

Whereas, the Board of Medical Examiners of the State of New Jersey has established regulations which empower it to look into the fees charged by physicians; and

Whereas, any attempt by physicians to come to an agreement on "reasonable fees" for specific services could be attacked by the Federal Trade Commission as an attempt at price fixing; and

Whereas, under the Medical Practice Act the Board of Medical Examiners assumes the right to influence the fees of physicians; and

Whereas, the Board of Medical Examiners cannot be deprived of the power to govern physicians' fees short of legislative action; now therefore be it

~~RESOLVED, that the Medical Society of New Jersey petition the State Legislature to exempt physicians' fees from the purview of the State Board of Medical Examiners.~~

Reference Committee felt that the Intent of Resolution #40E should be supported but recommended the following substitute resolution:

RESOLVED, that the Medical Society of New Jersey petition the State Board of Medical Examiners to refer all complaints on fees to the appropriate county society judicial committee for resolution. If the complaint against a member of the Medical Society of New Jersey cannot be resolved amicably at the local level, the findings and recommendations of the county judicial committee, either for or against, should be referred to the State Board of Medical Examiners for a final decision. (House amendment underscored.)

Substitute resolution recommended by the Reference Committee adopted as amended by the House.

REFERENCE COMMITTEE "B"

William E. Ryan, M.D., Chairman
Mercer

William A. Dwyer, Jr., M.D., Passaic

Robert J. Lorello, M.D., Essex

James J. O'Grady, M.D., Essex

Isabelo S. Torio, M.D., Middlesex

Joseph P. Murphy, M.D., Warren

Alternate Member

Reports:

Board of Trustees' Items

Treasurer

Committee on Finance

and Budget

Committee on Medical Student

Loan Fund

Committee on Publication

Resolutions #15, #19, #21, #27, #33, #34

Board of Trustees' Items

NEW JERSEY FOUNDATION FOR HEALTH CARE EVALUATION

(Reference Committee "B")

Interim Report on IPA/HMO

The recommendations of the Task Force on IPA Project adopted at the November 1979 Special Session of the House of Delegates were referred to the New Jersey Foundation for Health Care Evaluation for action. The following progress report on the activities taken in response to the recommendations was presented to the Board in February by Howard Zeidman, M.D., President of the Foundation:

Provide Information and Educational Services on IPA/HMOs to New Jersey Physicians

The provision of educational information on HMOs is a continuous service provided by the Foundation. On a periodic basis, it acts as a resource for providing information on HMOs as well as providing referral information. In the past few months, information has been provided to several sources throughout the State, including a member of the Legislature, a county medical society, and individual physicians and dentists. Technical expertise and assistance were provided to an IPA/HMO panel discussion sponsored by the West Jersey Hospital in December 1980, and as a result the hospital currently is pursuing activities to embark on an IPA feasibility project. In the future, the Foundation will take an active role in a statewide HMO employers' conference planned for the Spring of 1981.

Assist in the Formation of a Voluntary Organization of IPAs

An Association of IPA/HMO Directors was formed, which will meet bi-monthly. (Minutes of the first meeting held on December 16, 1980 are available.) The goal of the Association is to represent the interests of the individual practice associations in New Jersey. Topics to be addressed include: quality assurance, IPA solvency, emergency care, and periodic physicals.

Continue to Study the Progress of Existing HMOs

Ms. Shelley M. Ferrand, Assistant Director of the Foundation, showed slides to illustrate the present status of IPA/HMO activity in New Jersey. (At the present time, there are four operational IPAs and five staff model HMOs (one in the feasibility stage), with an approximate enrollment of 150,000.)

Many avenues are utilized to keep abreast of HMOs. The Foundation is actively involved with organizations that address HMO developments and issues statewide and na-

tionally. At the national level, it has provided representation at the American Public Health Association meeting, the Group Health Association of America, and the American Association of Foundations for Medical Care. At this time, projections for the future of HMOs are optimistic as private industry has begun to invest financially in the development of prepaid health care. However, active federal support is expected to decline to the point where no federal monies are dispensed for the development of HMO plans. (The HMO Act comes up for renewal in September 1981.)

At the state level, representatives of the Foundation attend the monthly meetings of the executive directors of New Jersey HMOs, which together with the meetings of the Association of IPA/HMO Medical Directors (mentioned above), should prove valuable to the ongoing study of HMO activities.

Study of Performance and Effectiveness of HMOs in New Jersey

A comprehensive evaluation of HMO performance is being undertaken, which will include a growth rate analysis of premium structure, analysis of utilization, and IPA case studies. A final report on the evaluation is expected to be completed in April 1981.

Since October 1980, periodic reports have been compiled on Crossroads Health Plan, which experienced financial difficulty. (Copies of two reports are available.) A final report of the details of the situation involving this IPA/HMO is expected to be completed in April 1981.

Assessment of Quality Assurance of HMOs

The HMO Act of 1973 mandates ongoing quality assurance programs in all federally qualified HMOs. In an effort to assess the quality assurance activities, an assessment of the status of such programs is being performed by the Foundation. In addition, an evaluation of patient satisfaction and experience also is being undertaken, with the voluntary cooperation of two IPAs, to determine how well the patients feel they are being served. The results of the survey will be reported in the Spring of 1981.

HSA Observation Organizations

At its meeting on November 16, 1980, the Board of

Trustees referred to the Foundation a recommendation submitted by the Council on Medical Services calling for the Board to explore the use of the Foundation as an avenue for cooperation and financial support in relation to physician participation in the HSAs.

Commenting on the referral, Doctor Zeidman reported:

A study was made to determine the relationship of organized medicine with HSAs on both a statewide and national basis. Many state medical societies engage in some form of activity in monitoring HSAs. While the methods differ, there appears to be a similarity of purpose (i.e., gathering information and physician input into the decision-making process). Since the Vanguard Program of the Medical Society of Virginia, which began some years ago, appeared to be the most ambitious project, the program was reviewed and the following conclusions were reached: (a) the early days of HSAs (1975-1979) brought about the establishment of virtually all state society programs; (b) all achieved a relative amount of success (i.e., gathering information and providing an awareness of the need for HSAs to deal with organized medicine); and (c) as more physician representatives of medical societies became involved at high levels in HSAs, the programs of the state societies diminished in funding and were diverted to other areas. In summary, the success of state programs depends upon the commitment of those involved in the monitoring process and clearly defined goals and objectives.

A study of the HSAs in New Jersey also was made, with respect to their involvement with county medical societies and physician input, as well as the impact and future of these organizations. The five HSAs have varying degrees of physician involvement. However, physician participation and selection in most areas is of a token nature. A more coordinated effort between organized physicians and HSAs was found in the northern part of the State. A further study will be made of a cooperative program established by the Bergen and Passaic County Medical Societies, together with the area hospitals and the New Jersey Hospital Association. The program is funded by the three groups, and the funds are used to hire a small staff which gathers information and acts as liaison to the HSA in the policymaking system. Overall, a

lack of physician input in the decision-making process was revealed.

The future of HSAs appears dubious. Like other federally funded programs, they are facing a cutback in funding, as well as the threat of consolidation.

Filed in accordance with the recommendation of the Reference Committee. (See Resolution # 33, page Tr 30)

REINSTATEMENT POLICY FOR DUES-DELINQUENT MEMBERS

(Reference Committee "B")

Last year, the Reference Committee on Constitution and Bylaws sent a referral to the Board suggesting that it establish a reinstatement policy for lost membership.

Under the existing policy, a member of the Society is determined to be dues-delinquent on June 1 and can be reinstated between June 1 and December 31 by paying the dues for that calendar year. If reentry is sought after December 31, the member must pay dues for the year he/she is rejoining, plus the dues for the year(s) lapsed between the time membership was dropped and the date of reentry.

RECOMMENDATION

That the House of Delegates approve the following policy for dues-delinquent members seeking reinstatement:

June 1 through December 31—Payment of the annual dues owed, plus a \$50 reinstatement fee.

Disapproved in accordance with the recommendation of the Reference Committee. (See Resolution # 21, page Tr 29)

After the close of a calendar year—Payment of the full dues of the current year, plus one year of delinquency.

Approved by action of the House.

Filed in accordance with the recommendation of the Reference Committee.

Treasurer

Rudolph C. Gering, M.D., Treasurer, Pennington

(Reference Committee "B")

These interim financial statements have been prepared in accordance with the accounting system recommended by our external auditors, Ernst and Whinney.

Since they are interim statements the figures are unaudited. However, a complete audit will be conducted of the

books of the Society as of May 31, 1981 and an audited report prepared as of that date. A complete audit was made as of May 31, 1980.

Filed in accordance with the recommendation of the Reference Committee.

Balance Sheet—January 31, 1981 (Unaudited)

Assets		
Cash		\$ 34,446
Marketable securities—at cost (approximates market)		1,078,675
Accounts receivable—member assessments		710,585
Medical Student Loans (Net of allowance for doubtful loans of \$40,000)		310,037
Notes receivable—Physicians		10,400
Property, Plant and Equipment		
Land	\$ 150,000	
Building and improvements	2,399,842	
Furniture and fixtures	346,055	
	2,895,897	
Less allowances for depreciation	(168,105)	2,727,792
Prepaid expenses		37,369
Other assets		12,370
		<u>\$4,921,674</u>
Liabilities and Fund Balance		
Accounts payable and accrued expenses	\$ 109,023	
Assessments collected for AMA	112,750	
Assessments collected for NJFCE	92,373	
	314,146	
Mortgage Payable	1,579,325	
Deferred revenue from member assessments	1,601,490	
Deferred professional liability assessments	568,938	
Fund Balance	857,775	
		<u>\$4,921,674</u>

Statement of Revenue and Expenses Eight Months Ended January 31, 1981 (Unaudited)

Revenue		
Membership dues	\$ 992,801	
Publication sales and advertising income	114,158	
Amortization of professional liability assessments	137,179	
Investment income	78,936	
Rental income	30,919	
Annual meeting	31,433	
Other income	29,871	
	Total Revenue	1,415,297
Expenses		
Conferences and meetings	258,054	
Member services	267,004	
Grants to medical institutions	10,000	
	Total Program Expenses	535,058
General and administrative	701,935	
Interest	105,647	
Depreciation	50,624	
	Total Expenses	1,393,264
Excess of Revenue Over Expenses		22,033
Fund Balance at June 1, 1980		835,742
Fund Balance at January 31, 1981		<u>\$ 857,775</u>

Finance and Budget

Richard E. Lang, M.D., Chairman, Passaic

(Reference Committee "B")

The Committee on Finance and Budget met on Wednesday, April 1, 1982 for the purpose of reviewing the proposed budget for the 1981-1982 year.

The Committee made the following recommendations which were approved by the Board of Trustees:

1. That the Budget for the fiscal year beginning June 1, 1981 and ending May 31, 1982 in the amount of \$2,252,000, with \$1,796,000 to be raised through member assessments be adopted. (See page Tr 26)

Approved in accordance with the recommendation of the Reference Committee.

2. That the 1982 assessment be set at \$245 per regular dues-paying member.

Approved in accordance with the recommendation of the Reference Committee.

3. That the 1982 assessment be set at \$25 per member for affiliate and associate members.

Approved in accordance with the recommendation of the Reference Committee.

4. That there be an assessment for 1982 of \$25 per member for licensed residents provided the individual is in a residency

program entered upon within a reasonable time after his or her graduation from medical school.

Approved in accordance with the recommendation of the Reference Committee.

5. That the 1982 assessment be set at \$5 per student for medical students.

Approved in accordance with the recommendation of the Reference Committee.

The following recommendation was not approved by the Board of Trustees and was referred for further study.

6. That a special assessment of \$20 be levied for the New Jersey Foundation for Health Care Evaluation.

Note: At its meeting on Friday, May 15, the Board of Trustees voted against approval of the above recommendation (#6).

No action was taken by the House on recommendation #6 since adoption of Resolution #33 (page Tr 30) makes further consideration superfluous.

Filed in accordance with the recommendation of the Reference Committee.

Statement of Revenue and Expenses for Proposed Budget Fiscal Year Ending May 31, 1982

Revenue (other than member assessments)	
Advertising income	\$ 90,000
Amortization of professional liability assessment	175,000
Investment income	60,000
Rental income	78,000
Annual Meeting	15,000
Other income	8,000
Membership Directory	30,000
Total	456,000
Expenses	
Conferences and meetings	356,800
Member services	295,000
Publications	170,500
Grants to medical institutions	3,000
Total Program Expenses	825,300
General and administrative	1,180,100
Interest	156,600
Depreciation	90,000
Total Expenses	2,252,000
Amount of expenses over revenue to be raised through member assessments (including Journal subscription and Annual Meeting assessment)	\$1,796,000

Revenue From Member Assessments Operating Year Ending May 31, 1982

(7 mos) 6/1/81 through 12/31/81 @ \$230.00 X 7600 =	\$1,020,000
(5 mos) 1/1/82 through 5/31/82 @ \$245.00 X 7600 =	776,000
	<u>\$1,796,000</u>

Proposed Budget
Fiscal Year Ending May 31, 1982

	Adopted Budget 1980-81	Estimated Y/E 5/31/81 (8 mos. Actual) (4 mos. Estim.)	Proposed Budget 1981-82
Compensation			
Salaries	\$ 620,000	\$ 593,918	\$ 673,000
Pension Plan	80,000	76,434	104,000
	<u>700,000</u>	<u>670,352</u>	<u>777,000</u>
Professional Fees			
Audit	12,000	14,986	13,500
Legal	15,000	18,874	15,000
Actuarial	2,000	1,368	1,400
Special Consultants	30,000	10,000	12,000
	<u>59,000</u>	<u>45,228</u>	<u>41,900</u>
Councils and Committees			
Public Relations	139,000	139,794	140,000
Legislation	12,000	23,000	25,000
President and presidential officers	35,000	31,723	33,000
AMA Delegates	44,000	62,263	50,000
MSNJ Auxiliary	14,000	14,000	19,000
Medical Education	29,000	29,000	30,000
Board of Trustees	35,000	36,000	37,000
Judicial Council	1,000	500	800
Reimbursement of representatives to meetings	3,500	5,200	6,000
Other Councils and Committees	13,000	15,000	16,000
	<u>325,500</u>	<u>356,480</u>	<u>356,800</u>
Member Service			
Membership Directory	60,000	50,000	—
Annual Meeting	80,000	90,000	120,000
Professional Liability Insurance Expenses	220,000	200,000	175,000
Journal	175,000	163,000	170,500
	<u>535,000</u>	<u>503,000</u>	<u>465,500</u>
Donations			
CMDNJ-Foundation	10,000	10,000	—
Medical Student Loan Fund	3,000	3,000	3,000
	<u>13,000</u>	<u>13,000</u>	<u>3,000</u>
General Administrative and Operating Expenses			
Building Operations— (including depreciation)	359,000	359,485	378,600
Insurance	61,000	57,967	62,500
Payroll taxes	50,000	44,000	48,000
Other general office cost	119,500	123,872	118,700
	<u>589,500</u>	<u>585,324</u>	<u>607,800</u>
Total	<u>\$2,222,000</u>	<u>\$2,173,384</u>	<u>\$2,252,000</u>

Medical Student Loan Fund

Palma E. Formica, M.D., Chairman, New Brunswick

Reference Committee "B")

In its twenty-four years of operation the Medical Student Loan Fund has granted loans totaling \$673,200.

To date, the Fund has issued 526 loans to 328 New Jersey residents attending medical school. Two hundred and fifty-three loans have been repaid in full. Forty borrowers presently are making quarterly loan repayments on an annual basis. Thirty-nine others are making quarterly interest payments until the notes become due. This year, thirty-four loans, totaling \$48,500, have been paid in full.

Forty-eight requests for financial assistance by New Jersey medical students were received during the 1980-1981 administrative year and thirty-nine loans of \$1,500 each were granted for a total of \$58,500. At the end of February 1981, three are in the final processing stage. If these meet all requirements, an additional three loans will be awarded making the total forty-two. This represents an increase of nine loans (\$13,500) over those awarded during the previous administrative year.

It is estimated that the Fund will have \$69,000 available for loans for the 1981-1982 academic year. Of this \$22,500 are committed to fifteen reapplicants. The remainder, \$46,500, will be distributed to thirty-one new applicants.

In view of the escalating medical school tuition, high interest rates on loans, and the inflationary impact on the cost of living more students will be faced by the need to seek loans. It seems more prudent to keep the yearly loan limit at its present level while striving to make loans available to additional students who qualify.

Your Committee has been greatly encouraged by the number of loans paid in full during the current year. The financial activities of the Medical Student Loan Fund are included in the report of the Treasurer. Your Committee is deeply grateful for the dedication and interest of the student interviewers and warmly commends Miss Patricia Drakeford for her administrative assistance.

PRESENT LOCATION OF RECIPIENTS OF LOANS

The 126 graduates with loans outstanding are located as follows:

Interns—5 in New Jersey and 11 out-of-state	16
Residents—7 in New Jersey and 53 out-of-state	60
Armed Services—1 United States Navy	1
Private Practice—	
1 Alabama	1 Arizona
2 California	1 Connecticut
4 Florida	1 Georgia
1 Hawaii	1 Illinois
1 Maryland	3 Massachusetts
19 New Jersey	4 New York
1 North Carolina	1 Oklahoma
4 Pennsylvania	1 South Carolina
1 Virginia	2 Washington, D.C.
Students presently in medical school—one, 5th Channel,	49
24 seniors, 13 juniors and 3 sophomores	41
Current loans outstanding	167
Medical students paid in full (253 loans)	161
Total New Jersey Medical Students	
(as listed earlier)	328

DISTRIBUTION OF LOANS

Since 1957, 328 students from eighteen counties attending

forty-five medical schools have received a total of \$673,200. Loans granted for 1980-1981 went to residents of twelve counties in fifteen medical schools and one CMDNJ-5th Channel Program. The complete list of loan distribution by county of residence, medical school, and the amounts of loans granted is on file at the Medical Society offices and is available for review.

CONTRIBUTIONS

The Committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

(1) **General Fund:**
MSNJ's Auxiliary Executive Board; County Auxiliaries: Bergen, Burlington, Camden, Cape May, Essex, Hudson, Mercer, Middlesex, Ocean, Passaic, Salem, Sussex, Union and Warren; MSNJ Board of Trustees; Medical Societies: Cape May; Dr. and Mrs. Sharbrokh Ahkami; Elwood J. Bibko; Dr. and Mrs. Richard Bloomenstein; Dr. and Mrs. Louis G. Bosco; Mrs. Clarence Boyle, Jr.; Dr. and Mrs. John Cammarata; Dr. and Mrs. Robert A. Cornwell; Mrs. Margaret N. DeYoe; Dr. and Mrs. Richard Fadil; Dr. and Mrs. Philip Fiscella; Salvatore Gagliano, M.D.; Roger Gerry; Dr. and Mrs. Leonard Gold; Mr. and Mrs. Harold W. Graham; Dr. and Mrs. John Hampton; Dr. and Mrs. Paul J. Hirsch; Joseph R. Jehl, M.D.; Dr. and Mrs. Dominic A. Kujda; Dr. and Mrs. Arthur Lawrence; Mrs. Dorothy C. Lemmon; Dr. and Mrs. Samuel J. Lloyd; Dr. and Mrs. Thomas F. McBride, Jr.; W. E. Mewhinney; E. Marion Mike; Dr. and Mrs. A. Gerard Peters; Dr. and Mrs. Paul H. Pettit; Mrs. Paul Rauschenbach; Dr. and Mrs. Thomas F. Reilly; Mrs. Enola S. Rubel; Mrs. Lily M. Smith; Mrs. Joseph M. Smolev; George S. Stevenson, M.D.; Evelyn E. Stone; Helen B. Stone; Mrs. Mildred Tarchiani; Mr. and Mrs. Thomas J. Walsh, Jr.; Dr. and Mrs. Irving Weiss; Donald, Edith and Sally Willett; Mrs. Adeline W. Wyman; Bettina L. Wyman; Dr. and Mrs. Mohamad H. Zanjani.

(2) **In Memory of:**
Mrs. Ahkami's Father; Alexander U. Bertland, M.D.; Mrs. Jennie Brandt; Ralph M.L. Buchanan, M.D.; Agnes W. Carroll; Mrs. Coleman; Vincent Fiscella; Hugh Flood, M.D.; Barbara Susan Gold; Martin Gold, M.D.; Michael Gratch, M.D.; James A. Gregorio; Mrs. Kathryn W. Hadtke; Bryan Harper; Keith E. Harper; H. Hale Hollingsworth, M.D.; Mrs. Bessie Hughes; Harold F. Hughes; Jeffrey Lipson, M.D.; John Lloyd, Jr.; Thomas H. McGlade, M.D.; Father of Klaus H.H. Meckeler, M.D.; Edith Bashore Ogden; Isaac N. Patterson, M.D.; Bernard D. Pinck, M.D.; Helen Richmond; Joseph A. Rube, M.D.; Isadore M. Schnee, M.D.; Catherine Schneider; Samuel G. Scott, M.D.; Arthur Stulbach; Mrs. Roy Van Ness.

(3) **In Honor Of:**
Mrs. Elmer Grimes, Mrs. J. James Pegues.

RECOMMENDATIONS

(a) That the MSNJ membership be urged to continue its active support by sending contributions to the Fund.

Approved in accordance with the recommendation of the Reference Committee.

(b) That the Medical Society of New Jersey Auxiliary be requested to make the Fund its number one project next year.

Approved in accordance with the recommendation of the Reference Committee.

Filed with commendation to the chairman in accordance with recommendation of the Reference Committee.

Publication

Paul J. Hirsch, M.D., Chairman, Bridgewater

(Reference Committee "B")

The Publication Committee has initiated a schedule of regular quarterly meetings during this past year. *The Journal* has continued to improve. The new graphics and the coordination of covers with specific articles have added to the attractiveness and readability of *The Journal*. There has been a high level of quality in the standard of the scientific articles.

REVIEW OF EACH ISSUE

At each meeting the preceding three issues of *The Journal* are critiqued and reviewed carefully, in conjunction with *Journal* Editor, Dr. Arthur Krosnick.

ADVERTISING

New advertising rates, effective January 1981, were approved by the Committee. These rates represent an average increase of 9.56 percent.

CME ADVERTISING

The Committee approved discount rates to encourage advertising regarding continuing medical education. A similar discount rate has been given to the Academy of Medicine for advertising its programs.

MICROFILMING

The Committee has recommended microfilming of the *Transactions* of MSNJ (1766 to 1903) and also microfilming of *The Journals* from 1904 through 1973. This has been

approved by the Board of Trustees. (All issues subsequent to 1973 are already on microfilm.)

CONTRACTS FOR 1981 PRODUCTION OF THE JOURNAL

Contracts with Hughes Corporation and with Trentypco, Inc., were approved for production of *The Journal* in 1981, and approved by the Board of Trustees.

IN-HOUSE TYPESETTING

Based upon a report submitted by Mr. Joseph W. Cookson, the Committee recommended against development of in-house typesetting by MSNJ at this time.

EDITORIAL BOARD

The name of the manuscript review board has been changed to Editorial Board. This reflects increased participation by this Board and recognizes the important contributions of its members. Several additional members were appointed to the Editorial Board during the past year.

SPECIAL SESSION

The Committee on Publication is planning a special session of the Committee, in conjunction with members of the Editorial Board, for Spring 1981.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

Resolution #15 entitled “An Award for MSNJ Members Who Pay Their Dues on Time” was withdrawn by the sponsor.

#19

Introduced by: **Essex County Medical Society**

Subject: **PAYMENT OF MSNJ DUES ON THE INSTALLMENT PLAN**

Referred to: **Reference Committee “B”**

Whereas, the cost of living has been rising steadily, and is expected to do so into the foreseeable future; and

Whereas, the business expenses associated with the practice of medicine have risen excessively, and will continue to do so; and

Whereas, the cost of membership in all medical societies has risen, and will continue to do so; and

Whereas, the total cost of membership in medical societies has become a major expense; and

Whereas, the lump-sum outlay of money for dues to the American Medical Association, the Medical Society of New Jersey, and the respective county societies has reached a level at which many physicians are experiencing serious financial difficulties in making voluntary payment of dues for membership in these organizations; and

Whereas, there will be a continuous loss of members during the coming years because of this difficulty—at a time when every medical society must go out of its way to retain each

member; and

Whereas, the principle of installment-paying has been a standard feature of modern living, and is even an elective expedient for making payments on professional insurance to the Medical Inter-Insurance Exchange of New Jersey, as well as making payments toward federal and state income taxes; now therefore be it

RESOLVED, that the 1981 House of Delegates direct the Board of Trustees of the Medical Society of New Jersey to provide immediately the necessary alternative mechanisms and arrangements for the payment of the 1982 MSNJ dues—and for all subsequent years—either by quarterly installments or by monthly installments, for those physicians who really want to retain their memberships in the Medical Society of New Jersey and in their county medical societies, but whose financial circumstances make this form of deferred payment a necessity.

Referred with Resolution #34 (see page Tr 31), in accordance with the recommendation of the Reference Committee, to the Board of Trustees for financial analysis and development of a format for component societies.

#21

Introduced by: **Essex County Medical Society**

Subject: **LATE FEE OF \$50 FOR MSNJ MEMBERS PAYING CURRENT DUES**

Referred to: **Reference Committee “B”**

Whereas, the Board of Trustees of the Medical Society of New Jersey has proposed that, beginning June 1, 1981, a late fee of \$50 be added as a penalty for those members who have not paid their current dues to MSNJ by that date; and

Whereas, many county societies have determined that such a step will be counterproductive, since it will cause additional resignations from the Society, conservatively estimated to equal at least eight percent of the total membership; and

Whereas, this is a critical time at which all medical organizations should be taking every step to encourage physicians to join and to maintain their memberships, while at the same time not taking any step that would discourage physicians from continuing their memberships; and

Whereas, the past policies of the Medical Society of New Jersey regarding the late payment of dues have salvaged a goodly number of members (conservatively estimated at 12

percent), who otherwise would have been lost—not just for one year, but for all succeeding years of their medical practices; now therefore be it

RESOLVED, that the 1981 House of Delegates reject the proposal by the Board of Trustees to impose a late fee of \$50 as a penalty on those members who pay their dues after June

1st of each year, since this proposal is unnecessary, undesirable, and counterproductive to the common goal of achieving a larger membership for the Medical Society of New Jersey.

Filed as a result of the action taken by the House on the Item "Reinstatement Policy for Dues-Delinquent Members" under "Board of Trustees' Items" in the report of Reference Committee "B" (see page Tr 23).

#27

Introduced by: **H. Irving Dunn, M.D., Delegate Ocean County**

Subject: **NEW AMA MEMBERSHIPS**

Referred to: **Reference Committee "B"**

Whereas, medicine in general is going through a period of serious intrusion by bureaucratic agencies; and

Whereas, there is a continuing need for vigilance and concerted action on a national basis; and

Whereas, medicine's cause is best served by a strong central body such as the American Medical Association; and

Whereas, the burden, financially and timewise, of the newly graduated intern and resident is recognized; and

Whereas, the Ocean County Medical Society is paying for the first half-year of membership dues in the American Medical Association as an encouragement to their membership; now therefore be it

RESOLVED, that all county medical societies be urged to pay one-half the first year dues for new AMA members.

Adopted in accordance with the recommendation of the Reference Committee.

#33

Introduced by: **Monmouth County Medical Society**

Subject: **DISCONTINUANCE OF FUNDING OF THE NEW JERSEY FOUNDATION FOR HEALTH CARE EVALUATION**

Referred to: **Reference Committee "B"**

Whereas, the New Jersey Foundation for Health Care Evaluation has been involved as the operating arm of Professional Standards Review Organizations; and

Whereas, it has provided information and advice toward the development of HMO and IPA plans; and

Whereas, it has failed satisfactorily to convince a majority of the members that these organizations function in their behalf; and

Whereas, this Foundation is contrary to present policy to

reduce costs and regulations of health care delivery; now therefore be it

RESOLVED, that the New Jersey Foundation for Health Care Evaluation no longer be funded by the Medical Society of New Jersey, and that any services necessary to the Society's membership be provided by the Board of Trustees or their appointees.

Adopted in accordance with the recommendation of the Reference Committee.

Introduced by: John Winslow, M.D., Delegate Essex County

Subject: **NEW DUES-PAYING METHODOLOGY FOR STATE AND AMA DUES**

Referred to: **Reference Committee "B"**

Whereas, the dues cost to practicing physicians for their membership in the county and state medical societies has had to go up with the combined effects of inflation and increased need for these organizations; and

Whereas, the dues for the American Medical Association have had to climb in the same fashion, and for even more need in the climate that has had to put medicine in a defensive and embattled position; and

Whereas, many practicing physicians would like to belong to the AMA but realize they do not have to do so and still practice medicine, or even belong to organized medicine at all, for that matter, and tend to back away when the large combined dues' bill comes in, getting to be in the range of their homeowner's insurance policy coverage costs; and

Whereas, one single large bill tends to have any person facing it back away if possible, a natural human tendency in these days of decreasing worth of the dollar; and

Whereas, insurance companies have found a good computerized billing system such as one that lets the payer pay 20 percent down the first month and then automatically get

billed on a monthly basis, with a minimum amount, and all for a service fee, but generally found to be of value to the payer looking for extension of payment time; and

Whereas, the county societies and the Medical Society of New Jersey, and certainly the parent American Medical Association, are in real need of increased and retained membership in order to truly represent medicine in our society; now therefore be it

RESOLVED, that the Medical Society of New Jersey, and also the American Medical Association, actively look into and implement a system for deferred computerized billings as a mechanism for increasing the membership of practicing physicians in the ranks of organized medicine at this time when this is so needed, and that the New Jersey delegates to the AMA actively push for the study and quick implementation of such a billing method.

Referred with Resolution #19 (page Tr 29), in accordance with the recommendation of the Reference Committee, to the Board of Trustees for financial analysis and development of a format for component societies.

REFERENCE COMMITTEE "C"

Richard H. DuPree, M.D., Gloucester
Chairman

William H. Coleman, M.D., Mercer
Roland E. Johnson, M.D., Sussex
Joseph A. Furey, M.D., Cape May
B. Ralph Wayman, Jr., M.D., Mercer
Felix G. Salerno, M.D., Hunterdon
Alternate Member

Reports:

**Medical Inter-Insurance Exchange
of New Jersey
Department of Professional Liability
Control
Committee on Medical Defense
and Insurance
Committee on Retirement Plan
for Physicians**

Resolutions #1, #3, #4, #30, #31, #41

New Jersey State Medical Underwriters, Inc. Medical Inter-Insurance Exchange of New Jersey

Vincent A. Maressa, Secretary-Treasurer

(Reference Committee "C")

This year has seen some changes in the New Jersey professional liability market. The State Reinsurance Association has been granted perpetual existence by the New Jersey Legislature, and has a 28 percent rate increase pending before the State Department of Insurance. The Health Care Insurance Exchange (New Jersey Hospital Association) has received approval from the Department of Insurance to underwrite "claims made" coverage for physicians. They will be marketing their product in April. First year rates will be about 50 percent of those for the normal occurrence policy. A commercial carrier, St. Paul, has indicated that it too will write "claims made" physician insurance in our State.

While this type of insurance effects a lower premium during the first several years of coverage, premiums become equal to "occurrence" type insurance around the fourth and fifth years. Additionally, upon leaving the "claims made" carrier, the physician must purchase "tail coverage" or risk being uninsured for any claim not reported in an active policy year. The same element is present in case of retirement or death. Please thoroughly research available sources and materials before making a decision of the "claims made" concept.

MEMBERSHIP

Over 5,900 physicians were insured in 1980, which represents a three percent increase over 1979. More than 600 members have taken advantage of part-time coverage, and the new practitioner discount has proved attractive.

PREMIUM

Annual premium (1980) exceeded \$32 million, and a 9.7 percent increase is awaiting approval of the New Jersey Department of Insurance.

POLICY IMPROVEMENTS

A new level of limits, \$200,000/\$600,000 is now available. The rate for this coverage is 16 percent above the \$100,000/\$300,000 rate.

The reimbursement rate for doctors who spend time in court in defense of a malpractice claim will be increased from \$25 per day to \$200 per half day, provided the Insurance Department grants approval.

CLAIMS

Forty-four percent of all known claims and suits were reported in 1980. More than half the loss payments were made in that year as well. There have been 1,396 claims and suits; 662 of these have been closed. Half that number (331) resulted in indemnity payments which have totaled \$17,534,800.

Rule 4:21 panels are viewed as being effective. The system continues to undergo and survive legal challenge.

INVESTMENT

Investments continue to perform well with a return in excess of 11 percent. Some \$12.7 million in income was realized in 1980. Aggregated investment return through December 31, 1980 stands at \$27.11 million.

DATA SERVICES

The electronic data processing system is well established as both an administrative support tool and an analytical device aide.

The data system developed for the Exchange is being marketed in Washington and Minnesota. Other carriers and brokers continue to show an interest.

HEADQUARTERS

The New Jersey State Medical Underwriters and the Medical Inter-Insurance Exchange are now well settled in their specifically designed offices at the Medical Society of New Jersey headquarters. The details of a 25-year lease are in the process of finalization.

Filed in accordance with the recommendation of the Reference Committee.

Department of Professional Liability Control

James E. George, M.D., J.D., Director, Woodbury

(Reference Committee "C")

The following report capsulates the various preventive programs and projects the Department of Professional Liability Control has conducted during the past year.

PHYSICIAN LEGAL BULLETIN

Three times this year the Department published and mailed to all Society members a bulletin relative to medicolegal topics. The Department has complied with numerous requests from individuals and organizations for copies of the *Physician Legal Bulletin*. It is our opinion that the *Physician Legal Bulletin* has been well received by the Medical Society members and other interested parties.

PROFESSIONAL LIABILITY COMMENTARY

The Department has published a monthly commentary in *The Journal MSNJ*, to inform members of the Society of mutual concerns and to provide general information regarding professional liability. The commentary has been well received by the readership.

SEMINARS

The Department has conducted medicolegal seminars for the New Jersey Society of Plastic and Reconstructive Surgeons; the Medical Students Association of the College of Medicine and Dentistry of New Jersey; The New Jersey Society of Certified Nurse Anesthetists; a panel discussion of *Rule 4:21* at the 1980 Annual Meeting; the New Jersey Society of Internal Medicine; and two seminars for the New Jersey Society of Anesthesiologists.

Plans presently are being formulated to conduct a medicolegal seminar for medical assistants sponsored by the Bergen County Medical Society and a medicolegal seminar for the staff of Somerset Hospital as well as for three specialty society meetings at the Medical Society of New Jersey's 1981 Annual Meeting. Participating physicians have expressed positive comments regarding the information and worthiness of the seminars. Category I CME credit has been granted for attendance.

DIRECTORS OF MEDICAL EDUCATION SEMINAR

The Department worked with the New Jersey Academy of Medicine in the planning and presentation of a seminar for the Directors of Medical Education.

CLAIMS MANAGEMENT COMMITTEE

The Department met monthly with the Vice President, Director of Claims of the Medical Inter-Insurance Exchange

of New Jersey, to discuss mutual concerns regarding professional liability and its prevention.

POCKET CALENDAR

A pocket calendar was developed by the Department of Professional Liability Control in cooperation with the Medical Inter-Insurance Exchange of New Jersey as a tool to assist in the prevention of medical malpractice. Each month features a medical malpractice mini-lesson. The calendars were mailed to all MSNJ members as well as those physicians who are non-members of MSNJ but insured through MIENJ.

AMNIOCENTESIS PAMPHLET

The Department, in cooperation with MIENJ and the New Jersey Academy of Medicine, mailed a booklet entitled "Amniocentesis for Prenatal Chromosomal Diagnosis" to physicians in Obstetrics/Gynecology and Family Medicine.

VIDEO TAPING PROJECT

The Department developed five *professional liability video tapes aimed at specific medical specialties*. The three-quarter inch video tapes incorporate a "talk show" format featuring the Director of the Department and two physicians representing the medical specialty subject of the tape. Each of the 45 to 55 minute tapes is designed to encourage post-viewing discussion and is available for a \$45 rental fee. The five tapes are entitled: "Professional Liability and the Obstetrician/Gynecologist," "Professional Liability and the Orthopedic Surgeon," "Professional Liability and the Anesthesiologist," "Professional Liability and the General Surgeon," and "Professional Liability and Internal Medicine."

SILVER AWARD/AMA MEDICAL SPEAKERS

The Department received the Silver Award in Category VI of the 1980 National Awards Program for Medical Speakers for its presentation of the tape, "Professional Liability and the Anesthesiologist." The AMA sent a check in the amount of \$500 made payable to MSNJ for use in its speakers' program, in recognition of the Department's winning tape, and a plaque honoring the Director of the Department who was moderator of the tape.

Filed in accordance with the recommendation of the Reference Committee.

Medical Defense and Insurance

Michael J. Doyle, M.D., Chairman, Neptune

(Reference Committee "C")

In 1980, the major changes affecting our plans were as follows:

1. The Hospital-Money Plan's rate scale was reduced for all participants under age 65, and the Plan limits were increased to a maximum of \$100 daily for participants under 65 and to \$40 a day for participants over 65. Beginning with the February 1, 1981 anniversary renewals, all participants would receive bills indicating the lower rate scale and offering an additional \$20 daily indemnity on a guaranteed issue, non-medical basis. In many instances, the premium savings would provide for the full additional cost of the extra coverage. The additional \$20 a day would be offered to all participants, without age restrictions, even those past age 70.

2. Last year, the Committee studied and approved the offering of an additional life insurance program to the members, providing insurance protection in a range beyond that of our present policies. This plan was approved and is now in force. An introductory mailing just has been sent to all members by the Administrators, E. & W. Blanksteen Agency, Inc. The new program in the Accidental Life Insurance Company of California provides \$50,000 to \$1,000,000 of coverage, on a deeply discounted, yearly renewable term basis.

3. The maximum coverage under the Professional Overhead Expense Plan was increased, as of January, 1981, from \$5,000 to \$7,500 monthly.

ACCIDENT AND HEALTH INSURANCE

The Society's accident and health insurance programs are administered by the E. & W. Blanksteen Agency, Inc. This comprehensive disability income program now affords a monthly benefit of up to \$4,600 during total disability due to injury or sickness. The program consists of two parts: The Basic Plan and the Long-Term Plan. The plans differ primarily in the length of time benefits are payable. For an accident disability, the Basic Plan pays up to five years; the Long-Term Plan up to lifetime. For a sickness disability, the Basic Plan pays up to two years; the Long-Term Plan up to age 65 and beyond. Both the Basic Plan and the Long-Term Plan are underwritten by the Nationwide Life Insurance Company. Members may select coverage up to \$4,000 per month in the Basic Plan and up to \$4,000 per month in the Long-Term Plan, with a total amount not to exceed \$4,600 per month. As many as three policies are issuable to any member, for maximum flexibility. For example, a member may carry a Basic policy and two Long-Term policies, with different waiting periods and different amounts. The Company will rearrange policies and existing coverage to accommodate changing needs, within a three-policy limit.

Basic Plan—The Basic Disability Plan alone provides as much as \$4,000 monthly benefit. Benefits are payable from the first day of accident total disability for as long as five years, and from the eighth day of sickness total disability for as long as two years. Waiting periods of 30 or 60 days are available to provide reduced premiums for those whose circumstances make desirable a plan where benefits could begin on a later date than 1st day accident and 8th day sickness.

The plan also pays, at one-half the monthly rate, accident partial disability benefits for as long as six months. Also included in the plan are accidental death and dismemberment benefits. There are 3,474 basic policies covering our members, with some members having two basic policies. It is the practice of the administrator to combine two basic policies into one whenever members revise or increase their insurance programs, so as to simplify their recordkeeping.

Long-Term Professional Income Protection Plan—Members may carry up to \$4,000 under this plan. Benefits are payable for lifetime for accident total disability and to age 65 and beyond for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall into place; such as annuities, life insurance settlement options, and Social Security. The plan also affords six months of accident partial disability benefits, at half the monthly benefit rate. Benefits may begin from the 1st day accident, 8th day sickness, or 1st day hospitalization—or from the 15th, 31st, 61st, 91st or 181st day of disability, with appropriate reductions in premium. There are 2,182 members currently participating in this program, which began in 1965.

It is possible for a member to have the various disability plans in almost any combination of monthly benefit and plan, to fit personal requirements. The ideal goal for most doctors is to insure about two-thirds of monthly net income. More monthly benefit than this is unnecessary, inasmuch as all benefits are tax-free for federal income tax purposes. Members who apply for the Basic Plan within their new-member periods are issued coverage, within certain limits, without regard to medical history.

All of our accident and health policies have the guaranteed Conversion Provision Rider. Briefly, this rider provides that, if the Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society, the Company is committed to issue a guaranteed renewable policy for the same benefits as are provided for in the doctor's original policy.

MAJOR EXPENSE PLAN

The Society's Major Expense Plan is in the Nationwide Life Insurance Company. This program is especially designed to work in conjunction with any Blue Cross and/or Blue Shield contract you may carry. The combination of the new \$200 deductible Million-Dollar Major Expense Plan and some basic hospital coverage can provide excellent protection for you. Currently, there are 1,833 members participating in the Plan.

The coverage consists of two parts:

1. **Basic Coverage**—The \$15,000 Basic Coverage is subject to a \$200 deductible and is paid *regardless of any other insurance or service plan you may have*. Basic Coverage provides 100 percent of \$40 per day toward hospital room and board, in addition to any Blue Cross or basic hospital coverage; \$50 a shift for nursing (RN or LPN in hospital; RN out of hospital), and the scheduled amounts of the optional professional-fee coverage.

In addition, it provides 80 percent of various services and supplies when out of the hospital. It may include professional-fee coverage, on an optional basis, as described in the folder. All professional-fee payments are, as is all Basic Coverage, paid in addition to other payments—in particular, Blue Shield.

2. Million-Dollar Umbrella Coverage—This coverage is designed to take over where Blue Cross leaves off and becomes operative when \$15,000 of Umbrella Covered Expense has been incurred. Umbrella Covered Expense consists of 100 percent of full semi-private hospital care, including miscellaneous hospital expense, as well as full nursing charges in hospital, and 80 percent of certain services and supplies out of the hospital. Payments are made under the Million-Dollar Umbrella Coverage to the extent that they have not been paid by other policies, including this one. *But*—the Basic \$40 daily hospital benefit and the full semi-private benefit under the Umbrella can be payable simultaneously. This makes certain that payment will be made in the event the insured is confined to a private room in the hospital.

Thus, participants are assured of virtually complete hospital and nurse coverage, even after Blue Cross benefits have ended. Umbrella Covered Expenses do not include expenses eligible for payment by Medicare.

Unmarried, dependent children are covered to age 25. All members who are under age 70, their spouses under age 70, and members' employees and their families are eligible to apply. At eligibility for Medicare, coverage for such person automatically becomes modified Basic Coverage, with a \$15,000 maximum for each covered person, and with a deductible of \$750 or the amount of covered expense payable by Medicare, whichever is greater. Medicare Covered Expense includes hospital miscellaneous services. The optional Professional-Fee Coverage does not continue for those eligible for Medicare. Full coverage continues for covered persons not eligible for Medicare. The program is administered by E. & W. Blanksteen.

HOSPITAL-MONEY PLAN

Our Hospital-Money policy, administered by E. & W. Blanksteen Agency, Inc., provides \$40, \$50, \$60 or \$100 a day for each day of hospital confinement, up to a maximum of 365 days for any one confinement. It can cover member, spouse and dependent children. Benefits under this plan were increased and premiums reduced for all policies renewing after February 1, 1981. At present, 231 members participate in this program.

PROFESSIONAL OVERHEAD EXPENSE PROGRAM

Our Professional Overhead Expense Program is underwritten by the National Casualty Company and administered by the E. & W. Blanksteen Agency, Inc. It provides up to \$5,000 monthly benefit (\$7,500, commencing in 1981) beginning with the 31st day of total disability and lasting for as long as two full years. Currently, 554 members are covered under the Plan. In accordance with I.R.S. regulations, the premiums under this program are considered a business expense and are tax-deductible.

LIFE INSURANCE—NATIONWIDE LIFE INSURANCE COMPANY, BANKERS LIFE COMPANY OF DES MOINES, IOWA AND OCCIDENTAL LIFE INSURANCE COMPANY OF CALIFORNIA

We now are offering a new life insurance plan, in addition

to the Nationwide Life and Bankers Life plans. This plan, underwritten by the Occidental Life Insurance Company of California, provides from \$50,000 to \$1,000,000 of annual renewable term insurance. Members' spouses, children and employees may also be covered. Coverage is guaranteed renewable to age 75. Currently, over 2,000 members are covered under the Nationwide Life and Bankers Life programs, with approximately \$40,000,000 of insurance in force.

SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE PLAN

Our Six Point, High-Limit Accident Insurance Plan with the Nationwide Life Insurance Company provides up to \$200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance and even a total disability feature, at less than the usual cost of the accidental death benefit alone.

Coverage is issued under this program to members under the age of 70 and in the active practice of medicine, without regard to medical history. Special spouse coverage is available under this policy at very low cost. At present, 572 of our members participate in the program.

PROFESSIONAL CORPORATION

The Basic-Extended Plan, Long-Term Professional Income Protection Plan, Major Expense Plan, Hospital-Money Plan, Six Point, High-Limit Accident Insurance Plan, Overhead Expense Plan and Life Insurance Plan are adaptable for use in professional corporations, and the necessary assignment forms are available upon request from the administrator.

HEALTH INSURANCE

The Statewide Blue Cross/Blue Shield Program has completed a good year, giving participating doctors a dividend of nearly 12 percent of total paid premium. Because inflation continues to push up the cost of health care, however, a premium rate increase was necessary, effective July 1, 1980. This has been the *only* increase in the past three years. Claims experience figures for the 1980 plan year are not yet available.

In January, 1981, the new Blue Shield 14/20 Series was made available to members. Blue Shield 14/20 has proved to be an excellent option for member doctors because the level of benefits provided by 14/20 is only slightly less than that provided by the Prevailing Fee (UCR) schedule, yet it is a fixed fee schedule. An important advantage of a fixed fee schedule during periods of high inflation is that it helps to keep a ceiling on rising premium rates. An added advantage is that the high level of benefits reduces participants' dependence on major medical premium rates.

The 14/20 Series currently provides benefits that are approximately 90 percent higher than those provided by the 500 Series and approximately 40 percent higher than those provided by the 750 Series.

The Statewide Blue Cross/Blue Shield Program also now has a Coordination of Benefits (COB) feature. This feature eliminates the possibility of duplicate payments for the same claim while ensuring that all claimants receive the full amount of benefits to which they are entitled.

Pregnancy benefits for unmarried dependent children were added at no premium increase. These benefits are identical to those provided to enrollees and their spouses.

Administered by Donald F. Smith & Associates, the Statewide Blue Cross/Blue Shield Program provides mem-

bers with basic health insurance protection that, while competitively priced, is extremely comprehensive. For example:

- 120-day semi-private care *per admission*, rather than per benefit year;
- 120-day coverage for mental conditions, tuberculosis, polio and contagious diseases, rather than the standard 20 days;
- payment of *full semi-private rate* in non-member hospitals outside of New Jersey, rather than the standard \$30 per day payment;
- coverage for unmarried children until the end of the year in which they reach age 23, rather than age 19.

The program continues to have no pre-existing condition exclusions and coverage is available to members regardless of their previous medical history. Coverage is also available for a member doctor's full-time employees if he or she wishes to provide it as a fringe benefit program. Close to 6,000 member doctors and employees were covered by the Statewide Blue Cross/Blue Shield Program at the end of 1980.

As a result of claims experience during the plan year ended November 30, 1979, premium rates for the Major Medical Program were also increased, effective July 1, 1980. Despite this increase, however, premium rates for this coverage remain competitive.

Benefits are payable when expenses for covered illnesses

and accidents exceed the benefits available under the Statewide Blue Cross/Blue Shield Program plus a calendar year cash deductible of \$100. Highlighted here are other key aspects of the Major Medical Program:

- Benefits are payable on expenses incurred in or out of the hospital.
- There are unlimited lifetime benefits. (The maximum benefit per person per calendar year is \$50,000 except for out-of-hospital treatment of mental conditions, which is limited to \$1,000 per person per calendar year.)
- Expenses incurred by physician and surgeon charges are covered by the Plan.
- The full semi-private hospital room and board rate is a covered expense. If a private room is medically necessary, there is an additional allowance.
- Unmarried children are covered until the end of the year in which they reach age 23.

This Major Medical Program was drafted by Donald F. Smith & Associates and is available to any member under age 65 who has Blue Cross/Blue Shield coverage on a group basis. Coverage also may be provided for full-time employees as a fringe benefit. More than 2,500 doctors and employees from 18 counties now are covered by this program of supplemental health insurance.

Filed in accordance with the recommendation of the Reference Committee.

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

Both of the following plans administered by E. & W. Blanksteen Agency, Inc. and PRO Services, Inc. have been reviewed by the Committee and have been approved for sponsorship again this year.

HR-10 (KEOGH) VARIABLE ANNUITY RETIREMENT INVESTMENT PLAN

Our Keogh Plan provides tax-deductible contributions up to the lesser of \$7,500 or 15 percent of earned income. In addition, voluntary contributions of up to the lesser of \$2,500 or ten percent of earned income may be made, to take advantage of the tax-free compounding and favorable final funding guarantees.

This plan, established in 1970, is administered by E. & W. Blanksteen Agency, Inc., and underwritten by The Prudential Insurance Company of America.

On December 1, 1979, Prudential revised the Fixed Dollar Account for contributions made after March 1, 1980. The new Fixed Dollar Account would have a stated rate of interest and would not be subject to interest adjustments when interest rates gyrate as they have in the past. The old Fixed Dollar Account, also known as the "Current Interest Account" had its interest rate raised to 10-1/2 percent on December 1, 1979, which necessitated an interest adjustment. While the interest adjustment does not affect the annuity value of the account, when interest rates rise, it does affect,

adversely, the immediate cash surrender value. Holders of the Current Interest Account were given the right, until February 29, to convert to the new Fixed Dollar Account retroactive to November 30—thereby obtaining a refund of the interest adjustment. The Prudential sent explanatory material to the participants to assist them in this decision.

The program includes unique advantages, in addition to the well-known tax-saving and tax-shelter features of the Keogh Law:

1. A lifetime monthly variable payment, based on a common-stock portfolio. (The Variable Annuity)
2. A lifetime monthly fixed-dollar annuity.
3. Contributions even beyond age 70-1/2, as long as you are self-employed.
4. A death benefit guarantee so that if the participant dies during the accumulation period, his beneficiary never will receive less than the amount the participant has paid in.
5. Contributions can be made as often or seldom as you wish with no minimum requirements.

The plan has a splendid final funding mechanism consisting of a Group Variable or a group Fixed-Dollar Annuity, combined with tax-free government bond distributions. Many members who accumulate their funds elsewhere find it beneficial to transfer to this program at age 70-1/2 and take advantage of the final funding arrangement.

At a regular meeting of the Trustees, on October 15, 1980,

it was requested of the Administrator that they send a letter to members between the ages of 68 and 70 to call attention to the exceptional final funding arrangement of this plan. In the letter, the following advantages were described:

1. Funds which are accumulated in the Prudential program or any other program can be final-funded by Prudential.

2. The final funding can be in the form of installment payments or life annuities on both the Variable (common stock based) or Fixed Dollar (guaranteed interest rate) bases.

3. The periodic payment on either the annuity or installment payment can be made without current income tax consequences since the program provides for distribution of government retirement bonds or checks, at the option of the participant. This means that you can receive the mandatory distribution of your Keogh program . . . and yet not pay current income tax on it.

4. If you are still earning sufficient money to warrant a Keogh payment on it, you may continue to make contributions based on your income, receiving the full income tax deduction permitted by law, with distribution the following year on the same basis as above.

Throughout the state we have 476 plans in effect, covering 533 people (since a partnership has one plan for all partners, a retirement plan covering a partnership may have more than one physician-participant) with total deposits of \$6,950,147.97 since the plan's inception.

The Society has recognized that some of its members may see fit to practice in the form of a corporation. Therefore, the Committee recommended and the Society approved in 1970, the establishment of the Medical Society of New Jersey Retirement Plan Trust-B, which adopted a Corporate Master Retirement Plan, using the same funding agents as the Keogh program described above. This program, in the form of a Master Profit-Sharing Plan, permits corporations, one of whose employees is a member of the Society, to place up to 15 percent of payroll in a tax-sheltered program with the same flexibility and option as our Keogh program, using the Prudential Insurance Company's group Fixed-Dollar Annuity and group Variable Annuity.

This plan is administered by E. & W. Blanksteen Agency, Inc., who will be pleased to furnish members with full information concerning the plan, which should provide a substantial savings, since it is not necessary to have a plan and trust specially drawn for you. Many large corporations and other organizations use these same funding agents for their tax-deferred retirement plan, including that of our Administrator.

PRO SERVICES, INC.

Benefits—One of the outstanding benefits available to members is the group retirement plans and ancillary services available through our designated agent, PRO Services, Inc. The plans offered are all IRS qualified master prototypes.

IRA—These include both the regular IRA with contribu-

tions of up to \$1,750 per year and the new "Simplified Employee Pension Plan" which permits contributions of up to \$7,500 annually.

Keogh—Two plans are available—Defined Contribution and Defined Benefit.

Corporate Pension and Profit Sharing—Master Prototypes are available to fit any individual need. These include money purchases, as well as various defined benefit arrangements.

Investment Alternatives—While members are free to select from a wide range of marketable investment alternatives, many members have chosen to use one or a combination of PRO's mutual funds. They are: PRO Fund, Inc., a common stock mutual fund, Medical Technology Fund, a common stock fund which concentrates its portfolio in stocks of medically related companies and PRO Income Fund, Inc., a high quality income mutual fund.

According to "Lipper Analytical Services, Inc.," an independent mutual fund statistical service, the full year 1980 performance of Medical Technology was + 48.7 percent and + 15.8 percent for PRO Fund. PRO Income Fund provides an indicated annual yield of 11.2 percent based on per share dividends paid in 1980, divided by the price per share on January 31, 1981. This is not a representation of future results since the actual yield will vary depending on the dividends declared and the actual price paid for shares.

ERISA Compliance—This computerized service is available to all members for use with any qualified retirement plan. It removes the worry and burden of ERISA reporting. It assures that all required reports are generated and filed on time, every time, year in and year out.

It includes assembling information and completing the appropriate form 5500 Annual Report, the Summary Plan Description for employees, Pool Account Allocations, Participant Account Summaries and other necessary filings with both the government and employees. Annual fees are as follows: **Keogh**—\$175 plus \$25 per participant, **Corporate**—\$375 plus \$25 per participant.

Corporate Feasibility Analysis—Can you substantially increase your retirement plan contributions without reducing your after-tax spendable income? This analysis will provide the answer and show you and your adviser how it can be done. It provides many other useful ideas. The fee for this service is only \$250 and is fully tax deductible.

Guaranteed Issue Life Insurance—The Society Program permits life insurance as part of any Keogh or corporate plans offered for those individuals who have a need for this feature. In light of recent inflation and the important tax benefits now available from including life insurance in retirement plans, the amount of coverage available without proof of health has been substantially liberalized. This is a major benefit, especially for those members with a health problem.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#1

Introduced by: **Morris County Medical Society**

Subject: **MSP ASSIGNMENT OF MEDICAL BENEFITS**

Referred to: **Reference Committee "C"**

Whereas, the current policy of disallowing assignment of benefits gives MSP of New Jersey an unfair advantage over other medical insurance carriers; and

Whereas, some patients feel they not only have a right to medical care, but the right to retain medical payments intended for physician providers; and

Whereas, non-assignment of benefits should not be a "club" used to induce participation in Blue Shield; now therefore be it

RESOLVED, that the Medical Society of New Jersey peti-

tion the Commissioner of Insurance to permit assignment of medical benefits provided by Blue Shield of New Jersey to non-participating physicians; and be it further

RESOLVED, that for those patients whose gross income falls within the contract limits established by their specific Blue Shield contract, the physician's election to accept assignment will represent the payment of the bill in total.

Rejected in accordance with the recommendation of the Reference Committee.

Reference Committee felt that the "Blues" have the virtual guarantee of payment as their principal incentive to participate. This resolution would abrogate that.

#3

Introduced by: **Mercer County Medical Society**

Subject: **BLUE CROSS COVERAGE FOR REHABILITATION TREATMENT**

Referred to: **Reference Committee "C"**

Whereas, the Hospital Service Plan of New Jersey is a major insurance company involved in providing for health care benefits for many New Jersey citizens and is, in fact, the insurer for the members of the Medical Society of New Jersey; and

Whereas, the physicians in New Jersey are as concerned for the economic consequence of illness as are our patients; and

Whereas, the Hospital Service Plan of New Jersey provides little or no coverage for the rehabilitation treatment of disabling effects of disease and injury; and

Whereas, rehabilitation after serious disabling diseases and/or trauma is recognized as a reasonable and necessary part of medical care in order to restore patients to their maximum functional status; now therefore be it

RESOLVED, that the Medical Society of New Jersey advocate and support necessary changes in Blue Cross contracts to make possible adequate coverage for the necessary completion of rehabilitation treatment of patients requiring such services; and be it further

RESOLVED, that the present, unrealistic \$50 a year limit for rehabilitation treatment be changed so that rehabilitation treatment may be received on an outpatient basis whenever feasible and indicated, thereby avoiding expensive and extended hospitalizations.

Reference Committee recommended that Resolution #3 be referred to the ~~Committee on Medical Defense and Insurance~~ Board of Trustees for the identification of problems and for the determination of the need for this resolution. House deletion indicated and amendment underscored.

Adopted as amended by the House.

#4

Introduced by: Mercer County Medical Society

Subject: **TRANSMITTAL OF ASSIGNED BENEFIT PAYMENTS TO PHYSICIANS**

Referred to: **Reference Committee "C"**

Whereas, a number of insurance companies in the State of New Jersey are involved in providing for health care benefits of many New Jersey citizens and citizens of other states passing through the State of New Jersey; and

Whereas, the Commissioner of Insurance has influenced the policies of the insurance companies in the State of New Jersey; and

Whereas, on occasions these insurance companies sent payments to the patient for services rendered even though they have been assigned to the physician by the patient, and

at times the physician never receives the payment; now therefore be it

RESOLVED, that the Medical Society of New Jersey advocate that the Commissioner of Insurance mandate that insurance companies pay the physicians directly when benefits have been assigned by the patient.

Rejected in accordance with the recommendation of the Reference Committee.

Reference Committee felt that the intent of this resolution had been met in a prior session of the House.

#30

Introduced by: Christopher Babigian, M.D., Delegate Bergen County

Subject: **DUAL FEE SYSTEM**

Referred to: **Reference Committee "C"**

Whereas, medical services should be reimbursed on the basis of services rendered; and

Whereas, the dual fee system (specialist vs. generalist) is unfair and biased; and

Whereas, recent court decisions in the State of Michigan have decided against a dual reimbursement system (October, 1976) or fee discrimination; now therefore be it

RESOLVED, that the Medical Society of New Jersey take all action necessary to prevent fee discrimination by third party carriers and to assure that physicians are compensated for the service rendered rather than by specialty designation.

Reference Committee recommended that Resolution #30 be referred to the ~~Committee on Medical Defense and Insurance~~ Board of Trustees to study the Michigan experience over a period of time and the consequences thereof. House deletion indicated and amendment underscored.

Adopted as amended by the House.

#31

Introduced by: Bergen County Medical Society

Subject: **INSURANCE COMPANY FEE DISPUTES**

Referred to: **Reference Committee "C"**

Whereas, some insurance companies do not make payments to physicians and surgeons promptly; and

Whereas, some insurance companies hold up payment to physicians and surgeons due to fee disputes; and

Whereas, payments in cases of fee disputes are withheld from six months to two years; now therefore be it

RESOLVED, that the Medical Society of New Jersey notify

the insurance industry that fee disputes should be considered for arbitration and the uncontested amount paid promptly; and be it further

RESOLVED, that the negotiation conference take place promptly, and the remaining fee allowed be paid 15 days thereafter.

Adopted in accordance with the recommendation of the Reference Committee.

Introduced by: **Ocean County Medical Society**

Subject: **MEDICAL LIABILITY INSURANCE PREMIUM SCHEDULES**

Referred to: **Reference Committee "C"**

Whereas, the risk of medical malpractice action to any particular category of physicians is variable and dynamic, requiring frequent study and updating of loss experience data; and

Whereas, there is a general agreement that medical liability insurance premiums should reflect the actual cost and risk of providing insurance to any particular category or group; and

Whereas, the American Medical Association recently has adopted a resolution on equitable risk classification and medical liability premiums; and

Whereas, a similar resolution has been adopted by the state medical societies in 15 states; now therefore be it

RESOLVED, that the Medical Society of New Jersey support the concept that premiums for medical liability insurance should reflect the cost and risk of providing that insurance to each category insofar as it is feasible, based on accepted underwriting principles.

Rejected in accordance with the recommendation of the Reference Committee.

Reference Committee felt that the Board of Governors of MILENJ is composed of representatives of each specialty category and that the Exchange does delineate the cost and risk factors in these categories by premium adjustment.

REFERENCE COMMITTEE "D"

William A. Allgair, M.D., Middlesex
Chairman
William Kamerling, M.D., Camden
Henry A. Katz, M.D., Morris
Nicholas E. Marchione, M.D., Cumberland
John Winslow, M.D., Essex
James H. Spillane, M.D., Warren
Alternate Member

Reports:
Committee on Medical Education
Committee on Emergency Medical
Care
Committee on Medicine and
Religion

Resolutions # 17, # 32

Medical Education

Edwin W. Messey, M.D., Chairman, Willingboro

(Reference Committee "D")

The Committee on Medical Education is pleased to state that the mandate of 150 hours of credit over a three-year period, as ordered by the House of Delegates in 1972, is being met. Physicians not meeting the requirements for continuing medical education have been dropped from membership in the Society but many subsequently have reinstated their membership by submitting CME credits. We notified 94 members that their membership was being terminated as of December 31, 1980, but since that time reinstatements have reduced the figure to 61 terminations.

The Committee on Medical Education now has accredited 71 hospitals throughout the State of New Jersey. Nineteen were resurveyed this past year. All but two were approved to engage actively in CME Category I programs for their staffs and surrounding communities on a yearly basis. Those that were not approved can reapply as soon as they have corrected their deficiencies.

Many of you are unaware of the difficult problem of surveying hospitals to approve them for Category I CME. The hospitals must apply to our Committee and several forms must be submitted. They are reviewed by our staff. Then physician teams of two or three who do onsite visits must be coordinated. The team spends an entire day interviewing the hospital's Director of Medical Education, Medical Education Committee, department heads, librarian and other personnel responsible for CME in the hospital, as well as considering the objectives, programs, physical facilities, and anything else that has to do with CME. The ultimate goal is "better patient care." A report then has to be filled out by the surveyors with a summary of their findings and recommendations being submitted to the Committee on Medical Education for review and final approval.

A few of the issues that we are facing and attempting to solve in this program are: standardization of survey forms, the training of the surveyors, the very ethos of Category I credit and how the criteria applies to various size hospitals, the need or requirement for full or part-time DMEs and their cost effectiveness, the attitude of the medical staffs, department heads and administration of the hospital, and finally proper or adequate budget.

The American Medical Association withdrew from the

Liaison Committee on Continuing Medical Education (LCCME) in July 1979. Subsequently, the AMA House of Delegates at its Interim Meeting in December 1980, approved the bylaws of the Accreditation Council for Continuing Medical Education (ACCME). This means a new perspective regarding the accreditation of continuing medical education at the national level. (This effort resulted from the Board of Trustees' report recommending its creation.) The new organization became operational on January 1, 1981, and assumed the responsibility for national accreditation of organizations, institutions and agencies offering continuing medical education. The bylaws affirm that the state medical associations *will retain the responsibility for accreditation of intrastate continuing medical education*. All the intrastate institutions and organizations, which have been so accredited, will have their names included in the ACCME list of accredited sponsors of continuing medical education. The current Essentials and Guide to Essentials will continue to be used. A new set of Essentials are, however, under consideration. A task yet to be completed is a handbook explaining to surveyors and program directors the methods for complying with these Essentials. Our own State Committee has had an ad hoc committee working on standardization of forms and criteria for surveying hospitals for Category I CME for the past six months.

Anyone wishing to become a surveyor, or who would like to observe a survey can contact our CME staff in Lawrenceville—telephone 609-896-1766.

There are varying views on the value of CME in producing better patient care. Most of this debate centers on the inability to measure objectively the results of CME in terms of clinical performance. Regardless of this inability scientifically to measure the results we must honor the obligation to produce reasonable educational opportunity. To this end the Committee on Medical Education has made a special effort to provide for the educational needs of the membership. Individualized educational programs are available through the Philadelphia College of Physicians with their Practice Related Educational Program (PREP). This service is contracted directly between the physician and the Philadelphia College of Physicians. Participation in the PREP pro-

gram can be used to satisfy the CME requirements when 150 hours have been accumulated.

Filed in accordance with the recommendation of the Reference Committee.

Emergency Medical Care

Rudolf E. Schwaeble, M.D., Chairman, Mendham

(Reference Committee "D")

The Committee has been active in various aspects of emergency medicine as follows:

EMERGENCY MASS CASUALTY PROGRAM

The Statewide Emergency Mass Casualty Plan was tested by a live exercise held October 12, 1980, in Plainfield. The purpose of the exercise was to test the communications system, distribution and transfer of victims to participating hospitals and the response system of rescue squads. Initial response came from the police department who immediately notified area rescue squads. The hospitals involved were Muhlenberg (controlling hospital), Rahway, Middlesex General, St. Peter's, Elizabeth General and Memorial General. The exercise lasted one hour and 35 minutes and was a success.

CPR FOR INDUSTRY

The Committee recommended and the Board of Trustees approved that the Medical Society of New Jersey adopt a

policy to support cardiopulmonary resuscitation training in industry. Also, the CPR Program should be undertaken by all personnel in industry through a three-hour cardiac defender course, and it is urged (this is not a mandate) that supervisory and management personnel be trained in an eight-hour CPR recertification program with annual refresher training.

AMA BOARD OF TRUSTEES REPORT— CATEGORIZATION OF HOSPITAL EMERGENCY CAPABILITIES

The Committee is reviewing this report and will evaluate the specific categories which pertain to each specialty. Specific recommendations on these guidelines will be presented to the Board of Trustees of the Medical Society of New Jersey for their approval.

Filed in accordance with the recommendation of the Reference Committee.

Medicine and Religion

John S. Madara, M.D., Chairman, Salem

(Reference Committee "D")

At its reorganization meeting on March 12, 1980, the Committee on Medicine and Religion agreed that its Chairman, Doctor Thomas H. McGlade, would request the Board of Trustees to consider presenting a program at the 1981 Annual Meeting using a three-person panel, with moderator, on Saturday between 10 and 11:30 a.m. Before another meeting of the Committee was held, Doctor McGlade died.

After discussion with our theologian consultant, Doctor Russell L. McIntyre, a 90-minute seminar on "Ethics-Law-Medicine: The Impact of Ethical Values on Clinical Decision Making" was presented to the Committee on Annual Meeting for its approval. It subsequently was accepted by the Board of Trustees on November 16, 1980, and Doctor Baker appointed me Chairman to replace Doctor McGlade.

The panelists subsequently met with the Chairman on January 16, 1981, and decided on the following subjects:

Patients' Rights—Where Are We and Where Are We Going?
Russell L. McIntyre, Th.D., Director of Programs in Health Care Humanities and Chaplain, College of Medicine and Dentistry of New Jersey, Newark

Euthanasia—Where Are We and Where Are We Going?
Marvin S. Fish, Esq., Newark, Practicing Attorney and faculty member of the College of Medicine and Dentistry of New Jersey

Medical Ethics—Where Are We and Where Are We Going?
James S. Todd, M.D., Ridgewood, Member of the Board of Trustees of the American Medical Association

This seminar on medicine and religion will be held at the Annual Meeting on Saturday, May 16, 1981, between 9:30 and 11 a.m. The future recommendations of this Committee will be guided by the response to this program.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

17

Introduced by: **Seymour F. Kuvin, M.D., Delegate Essex County**

Subject: **DISCONTINUE MANDATORY CME REQUIREMENTS**

Referred to: **Reference Committee "D"**

Whereas, the concept of continuing medical education is a time-honored tradition of the medical profession; and

Whereas, the discipline of medicine requires a lifetime dedication to learning new and perhaps discarding old concepts; and

Whereas, purely scientific knowledge and techniques appear to be giving way to non-medical topics in recent course offerings with more emphasis on travel and recreation; and

Whereas, mandatory requirements of a specific number of credits are overly burdensome and have resulted in loss of membership in the Medical Society of New Jersey; and

Whereas, the educational benefit is not commensurate with

the required effort to comply; and

Whereas, there is a lessening of pressure to require CME credits by state legislatures and state medical societies; now therefore be it

RESOLVED, that the mandatory continuing medical education requirement of the Medical Society of New Jersey can be dropped and deleted from the Bylaws; and be it further

RESOLVED, that all physicians continue their CME activities on a voluntary basis.

Referred to the Committee on Medical Education for further study. Reference Committee recommendation had been for rejection.

32

Introduced by: **Daniel N. Burbank, M.D., Delegate Essex County**

Subject: **FUND FAMILY MEDICINE DEPARTMENT**

Referred to: **Reference Committee "D"**

Whereas, there is and will be accentuated a shortage of family physicians in New Jersey; and

Whereas, this shortage only can be alleviated by the training of family physicians from the very start of their medical education; and

Whereas, said training programs need students indoctrinated in the concepts of family practice and strongly identified with the aims of family practice; and

Whereas, New Jersey Medical School does not currently have a Department of Family Medicine; and

Whereas, the students of New Jersey Medical School cannot

obtain systematized, comprehensive exposure to family medicine; and

Whereas, the thrust of such programs is to supply an acutely needed specialty in the various areas of New Jersey; now therefore be it

RESOLVED, that the Medical Society of New Jersey request the New Jersey Legislature strongly to recommend and fund a Department of Family Medicine at the College of Medicine and Dentistry—New Jersey Medical School.

Adopted in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "E"

Winton H. Johnson, M.D., Sussex
Chairman
Carl A. Restivo, Sr., M.D., Hudson
Edward A. Schauer, M.D., Monmouth
Gabor Somjen, M.D., Morris
Robert H. Stackpole, M.D., Union
John H. Lifland, M.D., Somerset
Alternate Member

Reports:
Council on Legislation
Council on Public Relations
Resolutions #6, #10, #28, #29, #36

Legislation

Daniel J. O'Regan, M.D., Chairman, Jersey City

(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern during the First Annual Session of the 199th Legislature. The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies, and in items published in the *Membership Newsletter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings. Although a notice announcing the date of each of the Council's meetings is sent to all MSNJ's official intermediaries with New Jersey specialty societies, the attendance of those representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields. The Council on Legislation agreed that in order to fortify our stand on legislative bills and make our position known throughout the Society it be a standing policy to invite the chairman of each Council and Standing Committee to attend the legislative meetings and to give them the right, if they cannot attend, to select a representative.

Of the bills reported to the House in 1980, the following were signed into law:

APPROVED

S-153 Zane—Civil Immunity

Provides immunity from civil suit for the Medical Vision Advisory Panel and persons providing reports and recommendations with respect to a licensee's ability to safely operate a motor vehicle.

S-954 Scardino—State Medical Examiner Act

Amends existing statutes to include as a medical examiner case the "deaths of children under three years of age where the suspected cause is sudden infant death syndrome."

A-311 Visotcky—Employment of X-ray Technicians

Makes it a crime of the fourth degree to knowingly or negligently employ an x-ray technician who does not possess a valid certificate. (N.B. Bill, as amended, complies with MSNJ position.)

CURRENT STATE LEGISLATION

S-48 Scardino—Department of Public Advocate

Restructures the Division of Mental Health Advocacy within the Department to create a Division of Mental Health Legal Counseling and Assistance which shall be staffed by multi-disciplined personnel.

Jurisdiction is all encompassing and relates to counseling, advising, and representing patients on all admissions, confinements, or retainments in mental health facilities, transfers, treatments, etc. The Division also will have the right to inspect and visit, at any time, any center, clinic, hospital, or facility for patients who are mentally disordered. **DISAPPROVED**, because this bill takes the treatment of the patient out of the hands of the physician, provides an unbalanced legal representation, and would divert funds necessary for patient care to non-health areas.

S-865 Orechio—Electrologists Licensing Act

Authorizes the State Board of Medical Examiners to license electrologists. An electrologist is "a person who professionally removes hair from apparently normal skin of the human body by electrical, electronic, or other technical, scientific methods approved by the Board." The advisory board is to consist of three electrologists and three medical doctors, preferably dermatologists. **DISAPPROVED**, because existing public health controls make this legislation unnecessary.

S-1179 Skevin—Diethylstilbestrol Related Disorders

Requires the State Department of Health to establish screening programs to locate, diagnose, and refer to proper treatment those who were adversely exposed to DES. The State Department of Health is to file a report with the Legislature one year from the enactment of this legislation. **APPROVED**

S-1191 Maressa—Abortion

Permits

1. First trimester abortions by a physician when:
 - a) The woman certifies, in writing, as to informed consent which shall contain known possibilities of adverse future events, complications, physical condition of the fetus at the time of abortion.
 - b) There must be a twenty-four-hour waiting period between consent and the procedure.
 - c) Physicians violating this section are disorderly persons.
2. No abortion may be performed after the first trimester unless:
 - a) The woman is advised a live born infant may result.
 - b) The procedure is performed in the hospital.
3. No abortion may be performed on a viable fetus except to preserve maternal life or death.
4. When the fetus is viable, a second physician must be present and the effort must be made to save the life of the aborted fetus.
5. Twenty-four-hour parental notification is required for all women under the age of eighteen. If actual notice is not given, then seventy-two hour constructive notice must be given. **ACTIVE OPPOS-**

TION, because this bill is unnecessary and restrictive since the public health questions of the bill have been resolved through the joint regulations of the Department of Health and the State Board of Medical Examiners in concurrence with the New Jersey Obstetrical and Gynecological Society. This bill violates law established through United States Supreme Court decisions.

S-1200 Bedell—Contact Lens Dispensing

Creates the profession of contact lens dispensing and fitting for non-physicians and non-optometrists. Licensure and regulation would be through the Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians. A prescription by a licensed optometrist or physician would be required. **ACTIVE OPPOSITION**, to that portion of the bill referring to contact lenses, because MSNJ does not feel it would be beneficial to the health of the consumer. Contact lenses improperly used or fitted may cause irreparable damage to the cornea. The fitting of contact lenses should be done by the prescribing ophthalmologist or optometrist.

S-1232 Vreeland—Professional Service Corporations

Amends existing law to allow licensees in certain allied fields to be shareholders in professional service corporations with more broadly licensed individuals, i.e., physicians and dentists. **APPROVED**

S-1293 Feldman—Licensing of Speech Therapists and Audiologists

Creates a direct licensing system within the Division of Consumer Affairs for speech therapists and audiologists. Continuing education is mandated. The individuals so licensed would function independently. Physicians and their employees are exempt under the Act as long as the employee is not termed a "speech therapist or audiologist." **ACTION DEFERRED**, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

S-1321 Musto—Blue Shield

Amends the enabling act to provide that chiropractors be included as eligible providers when services are rendered within the scope of their practice. (N.B. The New Jersey State Board of Medical Examiners voted to approve this legislation 9/15/80.) **LAW c.158 ('80). NO ACTION**

S-1358 Scardino—Cystic Fibrosis

Extends the benefits of the cystic fibrosis program under the crippled children's program to adults with that disease. **APPROVED**

S-1367 Lipman—Hereditary Disorders

Creates a Commission on Hereditary Disorders. The Commission is to establish detection and management programs, gather and disseminate information, establish recordkeeping systems, investigate charges of discrimination, and continually evaluate the need and efficacy of State programs on hereditary disorders. **DISAPPROVED**, as it is unnecessary and duplicative. Current programs being sponsored by scientific and educational organizations appear adequate.

S-1390 Merlino—Medical Society of New Jersey

Permits the Medical Society of New Jersey to decide whether or not to extend representation within the House of Delegates to specialty societies. **ACTIVE SUPPORT**

S-1434 Scardino—Research of Efficacy of Schedule I Substances

Permits research projects on the therapeutic effect of Schedule I drugs in conformity with federal law. **APPROVED**

S-1517 Wallwork—Professional Boards and Commissions

Amends existing law to provide that the Governor may suspend any public member of a given board who is under investigation for misconduct, incompetency, neglect of duty, or other sufficient cause and appoint a successor therefor. Additionally, the Governor must remove any professional members from the given board, who have had their license suspended or revoked or have been reprimanded or fined for improper conduct under N.J.S.A. 45:1-14 (Professional Boards Act), N.J.S.A. 45:15-1 (Real Estate Brokers and Salesmen), or N.J.S.A. 45:24-1 (X-ray Technicians). **APPROVED**

S-1538 Vreeland—Psychiatric Hospitals

Permits a state hospital to designate a maximum security area for patients being evaluated or observed pursuant to temporary commitment order. **DISSAPPROVED**, as current provisions are adequate in the state mental hospitals for the patient population. In the case of criminal detention and observation, consultation can be provided at the jail site which is better equipped to provide maximum security. **S-1540 Skevin—Controlled Dangerous Substances**

Grants to the Department of Health, the ability to regulate and control the therapeutic research of marihuana in conformity with the Federal Drug Enforcement Administration (FDEA), Federal Drug Administration (FDA) and National Institute on Drug Abuse Protocol. **APPROVED**

S-1542—Civil Commitments

This bill would incorporate current court rules regarding review of civil commitments into statutory language and attempt to limit review to mental illness and potential danger to self or others. Theoretically, this would preclude discussions of medications, placements, and treatment modalities. (Practically, it would not achieve the result indicated.) **NO ACTION**

S-1557 Merlino—Workers' Compensation

Increases medical witness fees under workmen's compensation to \$250 maximum per individual and \$750 maximum in aggregate. **ACTIVE SUPPORT**

S-1578 Gagliano—(DRG) Diagnosis Related Group

The purpose of this bill is to postpone the implementation of the second phase of the diagnosis related group (DRG) health care cost program established under P.L. 1978 c.83. **ACTIVE SUPPORT**

S-1587 DiFrancesco—Health Care Facilities

This bill proposes to amend N.J.S.A. 26:21-1 et seq. to require the Health Care Facilities Financing Authority to secure legislative approval prior to authorizing the termination of emergency or acute care services in a given hospital. (N.B. This is really the statutory obligation of the HCAB.) **APPROVED**

S-1593 Hamilton—Group Health Insurance

Would allow health insurers to compensate marriage counselors acting within the scope of their license. **DISAPPROVED**, because marriage counseling is a social service, not a medical service.

SR-35 Hagedorn—Hospices

Requests the Commissioner of Health to delay for sixty days the adoption of a Manual of Standards of Hospices to permit further study. **NO ACTION**

A-229 Muhler—Nuisance Suits

Allows reasonable attorney fees to successful defendants in the case of any frivolous claims. (N.B. This also includes cross claims, third-party complaints, and counter claims.) **CONDITIONAL APPROVAL**, provided the bill is amended to delete the word "frivolous" and to include the provision that "the prevailing party, as a matter of law, be awarded all court costs and legal fees."

A-485 Schwartz—Disclosure of Laboratory Tests

Requires clinical laboratories—upon written request of the patient—to supply the patient with a copy of the report that the laboratory sent to the physician. **NO ACTION**

A-819 Bassano, et al—Controlled Dangerous Substances Research

Creates a research program within the State Department of Health. Patients not responding to conventional therapy will be allowed into the program. Drugs currently on the Federal Drug Administration experimental list, e.g., marihuana, etc., will be utilized under federal guidelines. The MSNJ will be given an active role, e.g., making recommendations to the Commissioner of Health for appointment to the Therapeutic Research and Treatment Qualification Review Board. **APPROVED**

A-928 Stockman, et al—An Act prohibiting demands for payment as a condition precedent for completion of insurance forms

Prohibits physicians from demanding payment from a patient for services rendered prior to completion of a medical claim form in connection with an insurance form or plan. **CONDITIONAL APPROVAL**, pending inclusion of the following amendment: The Health Insurance claim must contain an "assignment of benefit" as a condition for the mandatory completion of the insurance form.

A-1184 Orechio—Eye and Ear Examinations of School Children

Mandates boards of education to employ one or more optometrists to be known as the "school vision examiners" and one or more physicians to be known as "school hearing examiners." (The hearing examiners also may be the medical inspectors.) **ACTIVE OPPOSITION**, because the school physician already has the obligation to screen for physical defects including impairment of vision and hearing.

A-1332 Bassano—Marriage Licenses

Requires all female applicants for a marriage license, under 45 years of age, to show laboratory evidence of a rubella response test as a condition precedent to the issuance of a marriage license. The physician is to inform the applicant of the medical significance of the results of the serological test. **ACTION DEFERRED**, pending further information from MSNJ's Council on Public Health and the New Jersey Chapter, American Academy of Pediatrics.

Note: By action of the Board of Trustees MSNJ's position was amended to **APPROVED**.

A-1342 Bassano—Determination of (Rh) Factor

Requires physicians to take a blood specimen from women patients prior to delivery or abortion, but no later than twenty-four hours after abortion, delivery, or miscarriage. The blood shall be tested to determine (Rh) Factor and the woman shall be advised of these results. (No penalty proviso is included in the current version of the bill.) **DISAPPROVED**, because this procedure is already current practice and this bill would be unnecessary legislation.

A-1345 Bassano—Disposal of Radioactive Waste

Would require specific legislative approval of permanent disposal sites of radioactive materials within New Jersey. **NO ACTION**

A-1439 Weidel—Blood Donations

Provides for a \$25 deduction from gross income for each pint of blood a given taxpayer donates to nonprofit blood-collecting organizations. **NO ACTION**

A-1454 Hurley—Withholding or Withdrawing of Life-Sustaining Procedures in Event of Terminal Illness

Empowers adults to execute a statutory form of directive to their physicians providing for the withholding or withdrawing of life-sustaining procedures during a terminal illness. The directive would be valid for five years and provides immunity for physicians and other providers complying with such a directive.

"Life sustaining" means a modality or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which would serve only to artificially prolong the moment of death where in the judgment of the attending physician death is imminent whether or not such procedures are utilized. It does not include "the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain." **APPROVED**

A-1592 Herman—Abortion

Requires the Department of Health to prepare a booklet which outlines the medical risks of abortion as opposed to childbirth. Further, requires a complete listing of alternative services should the woman choose not to have an abortion. The booklet shall be made available to physicians. Physicians shall make copies available to women seeking abortions and shall respond to questions. The physician must secure an acknowledgement from the patient. (Forms to be provided by the Department of Health)

All health care facilities and physicians engaged in the provision of abortion services shall file reports with the Department of Health within ten days following the performance of abortions. Failure to comply with this Act is a disorderly person's offense and can lead to disciplinary proceeding under N.J.S. 45:9-1 et seq. **ACTIVE OPPOSITION**, because existing statutes and regulations in case law cover the appropriate health concerns of this legislation and constitutional issues would be raised under the format of this bill.

A-1608 Garvin—Reportable Disease

Requires optometrists and ophthalmologists to report confirmed cases of blindness (central visual acuity of 20/200 or less in the better eye) to the State Commission for the Blind and Visually Impaired. **APPROVED**

A-1613 Fortunato—Treatment of Compulsive Gamblers

Requires the Department of Health to establish and advertise a treatment center for compulsive gamblers and to solicit grant funds for the establishment and operation thereof. The Commission shall submit operational and fiscal reports to the Legislature on an annual basis. **APPROVED**

A-1643 Muhler—Prescriptions for Eyeglasses and Contact Lenses

Requires physicians and optometrists to supply patients with written prescriptions for their eyeglasses or contact lenses so that they may seek the dispenser of their "choice." **ACTIVE OPPOSITION**, to that portion of the bill referring to contact lenses, because MSNJ does not feel it would be beneficial to the health of the consumer. Contact lenses improperly used or fitted may cause irreparable damage to the cornea. The fitting of contact lenses should be done by the prescribing ophthalmologist or optometrist.

A-1665 Burgio—Rights of Nursing Home Residents

Grants nursing home residents the free choice of physician and the right to purchase medications from the pharmacy of their choice. **NO ACTION**

A-1710 Herman—Comparative Negligence

Amends the current statute to remove the bar that the plaintiff's negligence must exceed that of any defendant he seeks recovery against. Under this bill, if the aggregated negligence of the defendant exceeded the comparative negligence of the plaintiff, recovery would be permitted against all defendants on a pro rata basis. **NO ACTION**

A-1719 Herman—Selection of Medical Treatment

Permits patients to appoint agents to make decisions regarding

medical treatment when the patient is incapable of doing so for himself. The physician is to decide whether the principal is incapable of exercising the judgment necessary to informed consent which would then empower the agent to act on his behalf. **ACTIVE OPPOSITION**, because this bill places on the physician the duty of determining whether a patient is capable of judging the physician's actions and also because current legal procedures for this type of patient function well under court monitoring.

A-1725 Herman—Smoking in Health Care Facilities

Prohibits smoking in all health care facilities except for:

1. Private rooms or rooms where patients consent to smoking.
2. Waiting rooms or lobby if there is more than one. If not, smoking is permitted as long as there is adequate sectionalization.
3. Cafeteria with a capacity of fifty or more, as long as a nonsmoking section is designated.

Smoking is prohibited in the waiting rooms of private practitioners, unless there is more than one waiting room. **APPROVED**

A-1726 Herman—Smoking

Requires schools, colleges, universities, or professional schools to regulate smoking in their building complexes and to permit smoking only in certain designated areas. **APPROVED**

A-1750 Hardwick—Nursing Homes

Requires the Department of Health to determine factors of precedence for nursing home admission. Nursing homes in conformity with these criteria would then maintain numerical waiting lists. **DISAPPROVED**, because this bill appears to be impractical legislation.

A-1753 Otowski—Physicians' Assistants

Permits the use of physicians' assistants when the P.A. has a valid registration with the State Board of Medical Examiners, a protocol and job description filed with the Board, and a designated supervising physician who is on the premises at all times. An exception to the last requirement may be granted by the State Board only when the type of service and the instances of provision are precisely defined. **ACTIVE OPPOSITION**, because licensure and/or registration of physicians' assistants will neither contribute to the quality of medical care nor decrease the cost of medical care. (*House of Delegates/December 10, 1979*)

A-1764 Bornheimer—Dental X-rays

Provides that dental x-rays may be used only for diagnostic and treatment purposes and not to verify performance of dental services to health insurers, dental plans, etc. **APPROVED**

A-1840 Franks—Administrative Procedure Act Amendment

There are three principal benefits to this legislation. First, it will force the agencies and departments of state government to conduct more thorough analyses of the costs of proposed administrative actions. Secondly, it would afford all parties directly affected by the proposed actions the opportunity to present fiscal information and recommendations to the agency. Finally, this bill would alert the Legislature to the possible costs of the proposed action. **ACTIVE SUPPORT**

A-1881 Fortunato—Patient Profile Record

This bill would repeal the patient profile regulation of the Board of Pharmacy and preclude pharmacists from collection of medical history and medication data. **ACTION DEFERRED**, pending further information from the Pharmaceutical Society of New Jersey.

Note: By action of the Board of Trustees MSNJ's position was amended to **DISAPPROVED**, because the Medical Society of New Jersey is on record as having approved pharmacy patient profile records, and this legislation was and is clearly in the public interest.

A-1913 Brown—Smoking

Requires health care facilities to set aside not less than 30 percent nor more than 50 percent of total patient rooms as "no smoking allowed" rooms. **DISAPPROVED**, in favor of Assembly Bills 1725 and 1726.

A-1940 Bassano—Nursing Homes

Requires nursing homes to hold in reserve a Medicaid bed for fourteen days when the patient is transferred to a general hospital. **ACTIVE SUPPORT**

A-1946 Bate—Organ Removal

Permits physicians performing mandated autopsies to remove pituitary glands unless a contrary indication was previously given by the decedent or is declared by the next of kin. **ACTIVE SUPPORT**

A-2135 Burgio—Optometry

Provides that an optometrist who discovers any non-refractive eye disease or disorder must advise the patient, in writing, to seek

medical attention. **CONDITIONAL APPROVAL**, pending deletion of the words "in writing."

A-2168 Gluck—Patient Rights

This proposal would effect a statutory bill of rights for patients in general hospitals. It adds nothing to existing common law except detailed procedure. It provides that every person admitted to a general hospital shall have the right:

- a. To considerate and respectful care;
- b. To be informed, upon request, of the name of the physician responsible for coordinating his care;
- c. To obtain from the physician complete, current information concerning his diagnosis, treatment, and prognosis in terms he can reasonably be expected to understand. When it is not medically advisable to give this information to the patient, it shall be made available to another person on his behalf;
- d. To receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment and which, except for those emergency situations not requiring an informed consent, shall include as a minimum the specific procedure or treatment, the medically significant risks involved, and the possible duration of incapacitation, if any. The patient shall be advised of any medically significant alternatives for care or treatment;
- e. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of this action;
- f. To privacy to the extent consistent with providing adequate medical care to the patient. This shall not preclude discussion of a patient's case or examination of a patient by appropriate health care personnel;
- g. To privacy and confidentiality of all records pertaining to his treatment, except as otherwise provided by law or third party payment contract;
- h. To expect that within its capacity, the hospital will make reasonable response to his request for services;
- i. To be informed by the physician of any continuing health care requirements which may follow discharge;
- j. To be informed by the hospital of the necessity of transfer to another facility prior to the transfer and of any alternatives to it which may exist;
- k. To be informed, upon request, of other health care and educational institutions that the hospital has authorized to participate in his treatment;

l. To be advised if the hospital proposes to engage in or perform human research or experimentation and to refuse to participate in these projects;

m. To examine and receive an explanation of his bill regardless of source of payment;

n. To be advised of the hospital rules and regulations that apply to his conduct as a patient; and

o. To treat without discrimination as to race, age, religion, sex, national origin, or source of payment. **APPROVED**

A-2169 Stewart—Physical Therapists

This bill provides that physical therapists may deliver their services at the direction of licensed dentists. **NO ACTION**

A-2219 Bate—Confidential Communication

Makes it a disorderly persons offense for a physician to disclose a confidential communication to someone not involved in the care of the patient unless the communication is necessary for the physician or nurse to receive payment for his/her services. **CONDITIONAL APPROVAL**, pending clarification of the vague language of the bill.

A-2232 Kavanaugh—Health Care Facilities

This bill proposes to amend N.J.S.A. 26:21-1 et seq. to require the Health Care Facilities Financing Authority to secure legislative approval prior to authorizing the termination of emergency or acute-care services in a given hospital. (*N.B.* This is really the statutory obligation of the HCAB.) **APPROVED**

A-2234 Burstein—Professional Liability Insurance

Grants the Malpractice Reinsurance Association perpetual operation. LAW c. 12 (81). **APPROVED**

A-2252 Mays—Health Planning

Would prevent state officials from eliminating a hospital service unless it has been demonstrated that the hospital service constitutes a hazard to the public health. **APPROVED**

Filed with commendation to the Council in accordance with the recommendation of the Reference Committee.

Supplemental Report

(Reference Committee "E")

At 12 o'clock noon, Tuesday, January 13, 1981, the Second Annual Session of the 199th New Jersey Legislature was opened. As the Legislature is presently constituted, the Senate has 40 members consisting of 13 Republicans, 25 Democrats, and two vacancies. The Assembly has 80 members consisting of 36 Republicans and 44 Democrats. By means of legislative bulletins, the Society's official positions on all current State Legislation regularly are called to the attention of legislators as well as of component societies, county keymen, cooperating agencies, and county society executives.

The Society has adopted the following regular range of official positions concerning proposed legislation:

ACTIVE

SUPPORT All-out support of the measure

ACTIVE

OPPOSITION ... All-out opposition to the measure

CONDITIONAL

SUPPORT To indicate that the approval of the Society is conditional subject to the elimination of the unsatisfactory elements of the bill that are pointed out.

APPROVAL Commended as satisfactory, but not actively supported

DISAPPROVAL .. Rejected as unsatisfactory, but not actively opposed.

CURRENT STATE LEGISLATION

The Council offers this supplemental report covering items dealt with since the compilation of its Annual Report.

On March 23, 1981 the following bill was signed into law as c. 72 of the Laws of 1981.

A-819 Bassano—Controlled Dangerous Substances

Creates a highly controlled program in the Department of Health for the therapeutic use of certain controlled dangerous substances in the treatment of certain diseases. **APPROVED**

S-1653 Hamilton—Licensing and Regulation of Athletic Trainers

Creates an Advisory Committee under the State Board of Medical Examiners. Trainers are persons employed as such by a school, college, university, professional team, or amateur athletic association who function under the direction, advice, or consent of the licensed physician. Applicants must meet the athletic training curriculum requirements of a college approved by the Board and must have graduated therefrom. They also shall pass a written and oral practical examination. **ACTIVE OPPOSITION**, because this bill is unnecessary legislation and would create the pseudo-practice of medicine.

S-1668 Orechio—Professional Boards

Provides that at least one-fourth, but no more than one-third of the members of each professional board shall be public members. Further, provides for the allowance of per diems not to exceed \$100 per day nor \$2,500 annually. **ACTIVE OPPOSITION**, because the addition of more public members would dilute the number of physician members. Also, the subject concerning per diem raises is beyond MSNJ's prerogative.

S-1669 Orechio—Professional Boards

Amends the Uniform Powers and Enforcement Act to provide that charging a manifestly unconscionable fee constitutes professional misconduct. **NO ACTION**

Note: By action of the Board of Trustees MSNJ's position was amended to **APPROVED**.

S-3065 Bedell—State Board of Medical Examiners

Adds another chiropractor to the State Board of Medical Examiners. **ACTIVE OPPOSITION**, there is no demonstrative need for this type of legislation since adequate chiropractic representation is already in existence.

S-3090 Orechio—Bio-analytical Laboratory Director

Alters the licensure requirements for laboratory directors and would permit endorsement grants of specialty license when the applicant has been certified by a national agency. While the license ("specialty license") is issued by the State Board of Medical Examiners, recognition of the national certifying association would be through the Commissioner of Health. Applicants eligible for this endorsement would, if this amendment is not enacted, be required to complete successfully the current New Jersey examination. **ACTIVE OPPOSITION**, this bill would unnecessarily establish a dual licensure system in New Jersey which would not have consistent standards. By creating subcategories of licensure, staff costs for laboratory operations will increase without any anticipated improvement in quality assurance. Existing manpower and requirements are more than sufficient to assure adequate service to residents of New Jersey.

S-3116 Graves—Smoking

Regulates smoking in health care facilities and doctor's offices. (If there is only one waiting room—smoking is permitted as long as there is an adequate section for non-smokers.) **NO ACTION**

SCR-3004 Kennedy—Medicaid

Creates a study commission of eight legislators to evaluate the administrative structure of Medicaid. **NO ACTION**

A-1332 Bassano—Marriage Licenses

Requires all female applicants for a marriage license, under 45 years of age, to show laboratory evidence of a rubella response test as a condition precedent to the issuance of a marriage license. The physician is to inform the applicant of the medical significance of the results of the serological test. **DISAPPROVED**, because this type of testing would serve no real purpose and would cost the public thousands of dollars each year.

A-1881 Fortunato—Patient Profile Record

This bill would repeal the patient profile regulation of the Board of Pharmacy and preclude pharmacists from collection of medical history and medication data. **DISAPPROVED**, because the Medical Society of New Jersey is on record as having approved pharmacy patient profile records.

A-2135 Burgio—Optometry

Provides that an optometrist who discovers any non-refractive eye disease or disorder must advise the patient, in writing, to seek medical attention. **APPROVED**

A-2219 Bate—Confidential Communication

Makes it a disorderly persons offense for a physician to disclose a confidential communication to someone not involved in the care of the patient unless the communication is necessary for the physician or nurse to receive payment for his/her services. (N.B. The Council on Legislation, at the request of the Council on Mental Health recommended the revised opinion on this legislation.) **ACTIVE OPPOSITION**, because this legislation makes a breach of patient confidentiality a petty, disorderly offense without a compelling or sufficient reason. Presently, there are adequate remedies available at civil law to cover any "unauthorized disclosures." Further, there is the prospect of conflict with current required reporting statutes.

A-2308 Kern—Radiology Services

Requires Blue Shield to cover in-patient radiology services. **ACTIVE SUPPORT**

A-2324 Lesniak—Workmen's Compensation

This bill would provide that employed physicians treating fellow employees would be liable for negligent acts. **ACTIVE OPPOSITION**, this legislation is unnecessary and duplicative because there is already a process available for occupational suits through the workmen's compensation statutes.

A-2352 Kern—Medical Records (Health Care Facilities)

Provides that a medical care facility must allow the patient (or his representative) an opportunity to review his records without charge. Further provides that governmental agencies may have access to records when their agents are identified and for "emergency official reasons." (Analyst's Note: This bill is poorly drawn and over-reaching. "Emergency official reasons" is a rather obscure definition.) **ACTIVE OPPOSITION**: (See analyst's note)

A-2354 Kern—Insurance Privacy Act

Prohibits insurance entities from releasing identifiable data relative to insureds except when authorized by the written release of the insured. Information may be provided to governmental authorities

where disclosure is reasonably necessary to protect the legal interest of the insurance company. **NO ACTION**

A-2360 Lesniak—Professional Boards

Defines the "charging of a manifestly unconscionable fee" as professional misconduct subject to discipline. Provides that at least one-fourth, but no more than one-third of all professional boards shall be consumer representatives. **NO ACTION**

Note: By action of the Board of Trustees MSNJ's position was amended to **ACTIVE OPPOSITION**, because the addition of more public members would dilute the number of physician members. Also the subject concerning per diem raises is beyond MSNJ's prerogative.

A-2370 Fortunato—Professional Boards

Increases professional board membership of public members to at least one-fourth, but no more than one-third of total membership. Increases per diem for board service to \$100, but not to exceed \$2500 annually. **ACTIVE OPPOSITION**, because the addition of more public members would dilute the number of physician members. Also, the subject concerning per diem raises is beyond MSNJ's prerogative.

A-3009 Weidel—Prescription Legend Drug

Provides that stramonium preparation is to be regulated as a prescription legend drug. Makes the cultivation and production of stramonium illegal except for pharmaceutical producers. **ACTION DEFERRED**, pending further information from the NJ Pharmaceutical Association and the Ad Hoc Committee on Drug and Alcohol Abuse.

A-3051 Kalik—Uniform Enforcement Powers

Provides immunity for any person who, in good faith, provides information or services including personal testimony to licensing boards. In the event a civil suit is filed against said person, the Attorney General, in the exercise of his judgment, may defend that person. **NO ACTION**

A-3060 Schwartz—Hospital Medical Staffs

Would require that hospital bylaws provide for the granting of full staff privileges to licensed podiatrists. **ACTIVE OPPOSITION**, MSNJ does not believe that podiatrists should be granted full staff privileges. (Full staff privileges should not be legislated.)

A-3082 Maguire—Professional Liability

Provides for an extensive revision of Tort law in the following areas:

- (a) A two-year occurrence statute of limitations for adults.
 - (b) Actions for injuries to minors under seven would have to be commenced by age nine. Minors over seven have the action accrue on the two-year occurrence standard.
 - (c) An action based on breach of warranty, contract, guarantee, or insurance will not prevail unless evidenced by written verification of the practitioner.
 - (d) Standard of care is to be determined by the level within the "PSRO area" or the "same classified health care facilities."
 - (e) If negligence was the result of complying with State or Federal Law, the action is dismissed with prejudice.
 - (f) Plaintiff must prove injury and negligence—there are no presumptions. Expert evidence must be utilized except when:
 - (1) Foreign body unintentionally left during surgery.
 - (2) Procedure performed on wrong patient or wrong part of body.
 - (g) Tendered payments do not constitute evidence of an admission of liability.
 - (h) Damages for loss of income would be based on the average income in the most recent three year period subject to a maximum of \$1,000 per week.
 - (i) Essential services' damages limited to \$50 per day during the life of the injured party.
 - (j) In wrongful death actions, income payments would be paid to the surviving spouse. If there is no spouse—then to dependents under age 22 or when they become self-sustaining. If there are no dependents—no income payments are made.
 - (k) Funeral expenses limited to \$2,000
 - (l) Pain and suffering limited to \$100,000 provided the licensee had lost his license for willful and wanton negligence or misconduct.
 - (m) Punitive damages limited to \$100,000
 - (n) Attorneys fees are to be determined by the Court.
- Other Provisions of this Bill:
1. All practitioners must carry liability insurance in order to maintain a license.
 2. If insurance is not reasonably available, the practitioner is not

liable to patients.

3. Provisions in insurance policies at variance to the act are void.
4. Insurance companies must serve a 30-day written notice of cancellation on the insured and the licensing board.
5. Policies may be terminated only if (a) contractual terms are breached; (b) false statements; (c) failure to pay premiums.
6. Carriers must accept any applicant with a license. Selective underwriting is not permitted.

ACTION DEFERRED, pending further information from the Medical Inter-Insurance Exchange of New Jersey and the Committee on Medical Defense and Insurance.

A-3087 Bate—Motor Vehicle Vision Test

Amends the motor vehicle operator vision test to include both visual acuity and peripheral fields. **APPROVED**

A-3102 Herman—Generic Drug Act

Amends the Generic Drug Law to provide that unless the prescriber states "Brand necessary" or "Brand medically necessary" in his own handwriting, the pharmacist may substitute the drug of his choice. Further amendments would insulate the pharmacist from any liability except when he has illegally dispensed a product. **DISAPPROVED**, because physicians already have a working system concerning the "Generic Drug Act" which has not, as yet, been thoroughly evaluated for its effectiveness.

A-3142 Otowski—Bio-analytical Laboratory Director (Same as S-3090)

Alters the licensure requirements for laboratory directors and would permit endorsement grants of specialty license when the applicant has been certified by a national agency. While the license ("specialty license") is issued by the State Board of Medical Examiners, recognition of the national certifying association would be

through the Commissioner of Health. Applicants eligible for this endorsement would, if this amendment is not enacted, be required to complete successfully the current New Jersey examination. **ACTIVE OPPOSITION**, this bill would unnecessarily establish a dual licensing system in New Jersey which would not have consistent standards. By creating subcategories of licensure, staff costs for laboratory operations will increase without any anticipated improvement in quality assurance. Existing manpower and requirements are more than sufficient to assure adequate service to residents of New Jersey.

A-3173 Karcher—Hypnosis

Creates the profession of "Licensed Hypnotechnicians." Practitioners of the healing arts are exempt from the requirements of this act. The Hypnotechnician practices therapeutically only upon referral from a health care practitioner. A separate board of nine people is created. Two of the nine could be physicians. **ACTIVE OPPOSITION**, because there is no legislative need for this type of practitioner.

AJR-3002 McEnroe—Nurse Practitioner

Creates an eleven-person commission to study the proper role of nurse practitioners and to maximize their utilization through legislative means. Four members of the Commission are to be legislators, two public members, three state officers, and one representative from the Nurses Association and one from the New Jersey Hospital Association. **ACTIVE OPPOSITION**, because there is no demonstrative need for this type of legislation. (Board of Trustees, March 15, 1981)

Filed with commendation to the Council in accordance with the recommendation of the Reference Committee.

Public Relations

Frank J. Malta, M.D., Chairman, Toms River

(Reference Committee "E")

The Council on Public Relations has carried on a large variety of projects of a continuing nature which are listed below, has studied a variety of new projects and instituted those falling within the mandates of the House of Delegates and the Board of Trustees.

CONTINUING PROJECTS

a. Publication and distribution of:

- (1) *Membership Newsletter*
- (2) Monthly news releases on "Continuing Medical Education," "Why National Health Insurance Won't Fly," "Anatomy of a New Jersey Doctor," "Snow Shoveling for the Over 35 Crowd," and various other subjects ranging from DRGs and regionalization of health services to professional liability and the excessive cost of governmental regulation.

b. Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business interest and activities, including:

- (1) The Eye Health Screening Program
- (2) The Annual Meeting
- (3) Child Safety Week
- (4) Selected official programs and activities
- (5) Professional Liability—through newspaper articles explaining MSNJ's position on professional liability and the problems that are being reflected on patient care.

(6) Legislative Meetings—between MSNJ representatives and legislators regarding medical and health-related matters, such as the registration and/or licensing of physicians' assistants, professional liability, cost containment, DRGs, regionalization of health care services and the excessive cost of governmental regulations. These meetings were of particular value in promoting the above with the legislators.

(7) Updating the legislative keyman system for legislative public relation activities.

(8) JEMPAC—continued cooperation with JEMPAC in the preparation and dissemination of promotional material encouraging physicians and their spouses to become active politically.

c. Maintaining the Information Center at the Annual Meeting for the issuance of press releases regarding newsworthy items developed at the Annual Meeting.

d. The Golden Merit Award ceremony continues to be an important function at which our senior physicians who have been in practice 50 years receive special recognition. In 1980, 81 physicians were so recognized making a total of 1,261 since the awards began in 1957. The recipients and their families receive undivided attention from the state and county leaders prior to the formal awards ceremonies and during the reception that follows.

e. Encouragement of the continuance or establishment of orientation programs for new members by the component

societies.

- f. Encouragement of increased voluntary blood donations throughout the year and particularly during vacation time in the summer and over Thanksgiving and Christmas holidays.
- g. Encouragement of radio broadcasts under the auspices of component medical societies, as well as from the State Society.
- h. Encouragement of medical TV programs of informational value to the public.
- i. Diabetes Detection Week
- j. Placement services in *The Journal of MSNJ*
- k. Coordinate efforts of the Council on Public Relations with the Ad Hoc Committee on Drug Abuse for future MSNJ involvement in drug abuse education and prevention.

MAGAZINES

In April, September and January our ads appeared in *Time*, *Newsweek*, *U.S. News and World Report*, *Sports Illustrated* and *New Jersey Monthly*. Subjects covered in the magazines included "National Health Insurance," "Pretty Poisons," "Medical Milestones" and "Come Out Of Your Shell."

DIRECT MAIL

Each member of the Society receives three mailings per year. In 1980 the members were mailed posters dealing with "You Told Us You Don't Want National Health Insurance . . . Now We Suggest You Tell Your Congressman," "Our 10 Worst Mistakes" and "Medical Milestones."

TELEVISION

During 1980, public service announcements were aired out of New York and Philadelphia television stations including the major network affiliates. This is the only effective way to reach our New Jersey population via television. The 30-second PSA's were run out at all time periods including prime time. These PSA's included treatment of the following subjects: "Keeping Fit," "Alcoholism" and "Pretty Poisons."

RADIO

In an effort to cover the State of New Jersey fully via the radio waves, PSA's were mailed to ninety-five radio stations in New Jersey, Pennsylvania, New York and Delaware. We have tried to stay with the same subject matter on radio as is used in the newspaper and television. Radio is more difficult to monitor than television, however, the stations are relatively cooperative particularly in the small towns. Dover Drug Abuse Council requested permission to reuse the marihuana radio tape in their high school program.

TOMA

There was interest on the part of Dave Toma, a famous narcotic detective from Newark, in doing a television spot for us concerning the dangers of drugs for teenagers. This was taped for TV release and used by the media.

DRUG ABUSE

The Council on Public Relations in cooperation with the Ad Hoc Committee on Alcohol and Drug Abuse and the Department of Health arranged to mail a brochure on drug abuse to the membership.

MEMBERSHIP

A brochure is offered that outlines what membership does for the doctor and the professional community. This was offered to the county societies.

DR. TODD'S CAMPAIGN FOR AMA TRUSTEE

All promotional material was prepared by the Council on Public Relations for Doctor Todd's campaign for AMA Trustee.

The Council on Public Relations' guidelines for all advertising undertaken, whether free or paid should:

- a. Improve the public image of the medical profession through information.
- b. Increase physician participation in MSNJ organizational activities.
- c. Improve physician attendance at county and state medical society meetings.
- d. Provide health information of use to the public.
- e. Promote the private practice of medicine within a free enterprise system as the best way to provide efficient and accessible health care to the most people.

Recommendations for MSNJ membership participation, support and enhancement of the medical profession's public relations program:

- a. Keep abreast of current events through careful reading of the *Newsletter*, *The Journal of MSNJ*, and special news releases and other communications.
- b. Component society officers and executive secretaries circulate to their membership pertinent information from minutes of various meetings and other releases sent to them.
- c. More active participation in Medical Society programs at all levels including political action committees in the congressional districts.
- d. One hundred percent participation by component society presidents and presidents-elect in leadership workshops presented by MSNJ Board of Trustees. Invite appropriate MSNJ trustees to component medical society meetings and medical specialty society meetings to give reports on current MSNJ programs and services of interest to them.
- e. Component society officers or appropriate committees hold informal meetings with local representatives of the press and with state and federal legislators to establish lines of communication and discuss current medical society programs.

REFERRALS FROM THE HOUSE OF DELEGATES

a. **Expose Cost of Governmental Regulations**—Resolution #2—The House of Delegates adopted Resolution #2 directing the Council on Public Relations to give top priority to exposing to the public the high cost and adverse effect of governmental regulations on the cost of health care and, in particular, on the voluntary cost-containment effort. This has been done through the Public Relations releases with the news media.

b. **Diagnosis Related Group Program**—Resolutions #3 and #23—The House of Delegates adopted these resolutions which stated that MSNJ is opposed to the concept of Diagnosis Related Groups, that the Medical Society advocate a moratorium on further implementation of the DRG methodology until such time as the "experimental" involvement of the present 26 participating hospitals can be evaluated, and that MSNJ publicize and strongly emphasize that

the first priority for hospitalized patients must be quality medical care. Our PR releases have had a marked impact resulting in good communication.

c. **Golden Merit Award Ceremony**—Resolution #9—The House of Delegates directed that the Golden Merit

Award Ceremony be returned to the 1981 Annual Meeting and this has been done.

Filed with commendation to the Council in accordance with the recommendation of the Reference Committee.

Resolutions

#6

Introduced by: **Frank J. Primich, M.D., Delegate Hudson County**

Subject: **AFFIRMATION OF PRINCIPLES REGARDING UNNECESSARY REGULATION**

Referred to: **Reference Committee "E"**

Whereas, past policy decisions of the Medical Society of New Jersey have reflected a concession of the inevitability of governmental intrusion; and

Whereas, efforts to modify the impact of ill-conceived legislation through a posture of cooperation and collaboration merely have made physicians the scapegoats for the predictable failures; and

Whereas, there currently is strong general support for deregulation in all aspects of our lives; now therefore be it

RESOLVED, that MSNJ, henceforth, oppose any further

government intrusion which, after due deliberation, is deemed not to be in the best interests of ~~the physicians or their patients~~ **patients or physicians**; and be it further

RESOLVED, that MSNJ expend every effort to supply the necessary data to those legislators who are attempting to repeal or declare a moratorium regarding further extension of previously enacted laws and regulations to which the Society objects.

Adopted as amended by the Reference Committee as indicated in the first resolved.

#10

Introduced by: **Frank J. Primich, M.D., Delegate Hudson County**

Subject: **OPPOSITION TO FURTHER INTRUSION BY THE FEDERAL GOVERNMENT INTO THE PROVISION OF HEALTH INSURANCE**

Referred to: **Reference Committee "E"**

Whereas, proposals such as federal catastrophic health insurance have been proclaimed by sponsors as a further step toward national health insurance; and

Whereas, without any additional legislation the bureaucrats could convert a catastrophic plan into the all-encompassing form; and

Whereas, federal regulation or federal standards regarding private insurers are merely more palatable words for the same end result; and

Whereas, the current mood of the people and statements of the Reagan Administration advocate less regulation in all aspects of our lives; now therefore be it

RESOLVED, that the Medical Society of New Jersey oppose any additional forms of federally controlled health insurance.

Adopted in accordance with the recommendation of the Reference Committee.

#28

Introduced by: **L. Arne Skilbred, M.D., Delegate Essex County**

Subject: **STATUTE OF LIMITATIONS**

Referred to: **Reference Committee "E"**

Whereas, a recent decision of the State of New Jersey Supreme Court (Lynch vs. Rubacky) interprets the two-year Statute of Limitations starting when the patient actually perceives that malpractice has been committed; and

Whereas, this decision completely erodes any Statute of Limitations; and

Whereas, the lack of an effective statute further will extend the "tail" portion of suits that come in years after treatment; and

Whereas, this will be an additional burden of maintenance of records on retiring physicians; and

Whereas, this will place an additional hardship on widows of physicians in keeping medical records for many, many years; and

Whereas, this will further complicate the insurance company problem of estimating risk and charging sufficient premium for the "tail"; now therefore be it

RESOLVED, that the Medical Society of New Jersey draft appropriate legislation and cause such to be introduced in the Legislature, attempting to obtain a reasonable and strictly defined Statute of Limitations.

Adopted in accordance with the recommendation of the Reference Committee.

#29

Introduced by: **Christopher Babigian, M.D., Delegate Bergen County**

Subject: **PROGRAM EXTOLLING BENEFITS OF THE PRIVATE PRACTICE OF MEDICINE**

Referred to: **Reference Committee "E"**

Whereas, physicians believe in the idea of support of private practice of medicine in our county; and

Whereas, in recent years the government continually has expanded its intrusion into the private practice of medicine; and

Whereas, it is obvious that adequate education of the values

and benefits of the private practice of medicine has not been expounded to the public at large; now therefore be it

RESOLVED, that the Council on Public Relations develop and implement a program extolling the benefits of the private practice of medicine to the people of New Jersey.

Adopted in accordance with the recommendation of the Reference Committee.

#36

Introduced by: **Middlesex County Medical Society**

Subject: **GOVERNMENT REGULATIONS**

Referred to: **Reference Committee "E"**

Whereas, many laws and regulations, even if well-intentioned, produce unplanned and unwarranted economic hardship for those regulated; and

Whereas, public and private resources are finite; and

Whereas, modern techniques of cost-benefit and cost-effectiveness analyses are proving to be effective tools in controlling unnecessary expenditures; now therefore be it

RESOLVED, that laws or regulations proposed or pro-

mulgated by state, county, or municipal legislative bodies or regulatory agencies be required to attach fiscal notes and cost-benefit or cost-effectiveness analyses to those laws and regulations to which these techniques can be applied; and be it further

RESOLVED, that the Medical Society of New Jersey seek the introduction and passage of legislation to effect the foregoing "RESOLVED."

Rejected by the House. Reference Committee recommendation had been for adoption.

REFERENCE COMMITTEE "F"

Pascal A. Pironti, M.D., Union

Chairman

L. Glenn Barkalow, M.D., Monmouth

Thomas E. Mattingly, Jr., M.D., Burlington

Roger C. Laauwe, M.D., Passaic

Joseph A. Riggs, M.D., Camden

Joel S. Cherashore, M.D., Essex

Alternate Member

Reports:

Board of Trustees' Item

**Council on Medical Services and its
Special Committee on Occu-
pational Health, Workmen's Com-
pensation, and Rehabilitation**

Council on Mental Health

Committee on Drug and

Alcohol Abuse

Committee on Impaired Physicians

Committee on Medicaid

Membership Inquiry and Complaint

Committees

**Resolutions #2, #8, #9, #14, #16, #18,
#25, #26**

Board of Trustees' Item

DIAGNOSIS RELATED GROUPS

(Reference Committee "F")

The DRG project and S-446 require review of the care rendered to all patients. The professional standards review organizations in New Jersey have demonstrated the ability to conduct such reviews and have expressed the willingness to be the review agencies under the Health Department designation.

The Medical Society of New Jersey notified the Commissioner of Health in September that it supports the recognition of the PSROs as the review agencies for the entire DRG project. The Board of Trustees believes that it is essential to have the review and medical audit conducted by practicing physicians, as well as logical and consistent to have federal and non-federal patients reviewed by the same organization.

Filed in accordance with the recommendation of the Reference Committee.

MEMBERSHIP INQUIRY AND COMPLAINT COMMITTEES

(Reference Committee "F")

Four committees were established at the 1972 Special Session of the House of Delegates as a mechanism to deal more effectively with third party insurance carriers and governmental medical programs as they affected the practices of the membership. The committees have met infrequently, since most matters within their jurisdiction have been resolved to the physician's satisfaction by the staff of the Medical Society of New Jersey. With the creation of the Committee on Negotiations in 1979, the continuance of the committees presents an unnecessary duplication of effort and systems.

RECOMMENDATION

That the four Membership Inquiry and Complaint Committees be discharged and their duties assigned to the Committee on Negotiations.

Approved in accordance with the recommendation of the Reference Committee.

Medical Services

Victor H. Boogdanian, M.D., Chairman, New Brunswick

(Reference Committee "F")

The Council is charged with the responsibility of studying and evaluating matters relevant to maintenance and advancement of the standards and character of medical practice in New Jersey, and the investigation of the economic and social aspects of medical care.

BOARD OF TRUSTEES' REFERRAL—MEDICAID SURVEY OF OCEAN COUNTY BY PUBLIC ADVOCATE'S OFFICE

Ocean County Medical Society requested the Board of

Trustees to review a survey conducted by the Public Advocate of the Medicaid patients in Ocean County. The Council on Medical Services found that the Public Advocate conducted the survey because they received complaints regarding the availability of physician services. Ocean County Medical Society reported that they had set up a special Medicaid Complaint Board to handle complaints by Medicaid patients. In view of this the Council recommended and the Board of Trustees approved a letter being sent to the Public Advocate to the effect that although there may have

been legitimate complaints about the availability of physician services to Medicaid patients in Ocean County, the Council on Medical Services of MSNJ feels that it would have been more appropriate to work through the Ocean County Medical Society to solve these complaints and urged a closer liaison with their special Medicaid Complaint Board in the future; and that if the Public Advocate's Office does not achieve desired results in this way, they are urged to notify the Medical Society of New Jersey.

BOARD OF TRUSTEES' REFERRAL—HSA OBSERVATION ORGANIZATIONS

The Council was requested to review the matter of financing and support of HSA observation organizations at the State level by MSNJ. It was noted that physicians and their representatives were influential with consumers on the various HSA Boards and that this could be a potent arm against the bureaucrats. It was felt that the Council should explore the possibility of MSNJ seeking the cooperation of the New Jersey Foundation for Health Care Evaluation to encourage physician participation throughout the State and perhaps to develop monitoring services. The Board of Trustees at the suggestion of the Council requested the Foundation to supply such a study and report.

BOARD OF TRUSTEES' REFERRAL—HOUSE OF DELEGATES' RESOLUTION #5—OPPOSITION TO HEALTH SYSTEMS AGENCIES

Extensive review of printed materials, conferences with members of the Medical Society of New Jersey participating in Health System Agencies (HSAs) at county levels, correspondence with the County societies, and discussions in the Council on Medical Services meetings have led to the following recommendations that will be presented to the Board of Trustees for their review at the March 1981 meeting: (1) That MSNJ exert its influence via the AMA toward the ultimate repeal of Public Law 93-641 (National Health Planning and Resources Development Act); (2) That MSNJ seek to modify the functioning of HSAs in New Jersey so as to increase the capacity for local decision making, while reducing the power of the State and Federal Government to reverse or obstruct such decisions; (3) That MSNJ seek to enhance the involvement of its members in health planning; (4) That these recommendations be offered to the House of Delegates in 1981 in the form of a Resolution from the Board of Trustees that might be conveyed to the AMA House of Delegates for their vote as well.

These recommendations derive from the perception that the HSAs are not cost effective and tend to be arbitrary in granting or denying expansion of health services. It is also perceived that increased participation of physicians in the planning process at the county organizations and local hospitals will provide a substantial opportunity for improvement of health services in New Jersey.

SECOND OPINION PROGRAMS

The Council has reviewed second-opinion programs from several sources and has continued to recommend to the Board of Trustees that no individual program be endorsed. The Council further felt that all such programs must be on a voluntary basis to be acceptable and that no conclusions be published until adequate time has elapsed for realistic appraisal.

Filed in accordance with the recommendation of the Reference Committee.

Supplemental Report

(Reference Committee "F")

On March 11, 1981, the Board of Trustees of the New Jersey Hospital Association officially adopted the following position on No Code Orders as a guide for the hospitals in the State of New Jersey:

In the past six years there has been substantial discussion within the medical profession on the appropriateness and legality of physician orders not to resuscitate patients (referred to as No Code Orders). The appropriateness of such an order is always a medical decision to be made by the attending physician.¹

The legality of No Code Orders has been recognized when, in the judgment of the attending physician, the patient suffers from an incurable terminal illness and "... attempts to apply resuscitation, if successful, will do nothing to cure or relieve the illnesses which have brought the patient to the threshold of death..."² The basic premise is that there are situations where medical science knows no cure for the disease or illness, and no treatment is available which can slow or arrest its course.

The Board of Trustees recognizes that No Code Orders are medical decisions, dictated by sound medical practices and, as such, must be made by the attending physician. However, the New Jersey Hospital Association offers the following recommendations relative to the implementation of No Code Orders:

The order should be written in the patient's chart. As a treatment order, it must be written and signed by a licensed physician. New Jersey law, the Joint Commission's Standards for Hospital Accreditation, as well as sound medical practice, require that the order be written in the patient's chart. It may be accompanied by positive language such as "routine nursing care only."

The physician writing the order thoroughly should document the patient's medical condition and the circumstances. The documentation shall indicate that the patient suffers from a terminal illness for which there is no prospect of further beneficial therapy to cure or relieve the illness. The physician should document on the patient's chart not only his professional opinion and judgment but also the date, time and identity of those persons with whom he has discussed the No Code Order, including the patient, the involved close relatives or, if applicable, the patient's guardian or conservator, as well as recording the substance of any physician consultations. This documentation should appear on the medical record before such order is written.

In summary, the written documentation should reflect that the order is consistent with sound medical practices and should provide positive written evidence to support the physician's conclusions as well as recording consultations with the patient, the patient's family, the patient's guardian or conservator, where applicable.

The foregoing recommendations are not applicable in situations concerning the withdrawal of life support systems.

(This Position Paper on No Code Orders, presented by the New Jersey Hospital Association, was adopted by the Board of Trustees at its meeting on May 15, 1981.)

¹Rabkin MT, et al: Orders not to resuscitate. *N Engl J Med* 295:364, August 12, 1976

²In the Matter of Shirley Dinnerstein. ____ Mass. App. ____ 380 N.E. 2nd, 134 (Mass. App. Ct. 1978)

Filed in accordance with the recommendation of the Reference Committee.

Occupational Health, Workmen's Compensation, and Rehabilitation

Maurice E. Goldman, M.D., Chairman, Linden

(Reference Committee "F")

The Committee on Occupational Health, Workmen's Compensation and Rehabilitation endorsed the definitions of disability and impairment as presented in the "AMA Guideline to the Evaluation of Permanent Impairment." Describing impairment is a medical matter involving scientific and generally reproducible observations. The concept of disability on the other hand involves societal and legal concepts beyond the expertise of physicians. It was recommended by the committee that in workmen's compensation cases, physicians testify as to the medical impairment produced by an accident or injury. The "AMA Guidelines to the

Evaluation of Permanent Impairment" was endorsed as an excellent guide and reference for physicians asked to ascertain the degree of impairment.

Senate Bill #3362 involving noise-induced hearing loss was reviewed. Also, Senate Bill #1557 relating to increasing fees for workmen's compensation cases was approved and referred to the Council on Legislation for its review.

Filed in accordance with the recommendation of the Reference Committee.

Mental Health

Harry H. Brunt, M.D., Chairman, Neptune

(Reference Committee "F")

The Council on Mental Health met three times prior to this report, September 10, 1980, November 12, 1980, and January 14, 1981. The Council reviewed S-48, sponsored by Senator Scardino, which would restructure the division of Mental Health Advocate to create a division of Mental Health Legal Counseling. The Mental Health Council was opposed to this legislation since it took treatment of patients out of the hands of the physicians.

A great deal of time was spent on new policies promulgated by the Department of Human Services through administrative fiat. These Rules and Regulations for Community Mental Health Agencies will go into effect July 1, 1981, in spite of opposition to them.

Continued discussion was held on Resolution 24 concerning the treatment of compulsive gamblers. A-1613, sponsored by Assemblyman Fortunato, was approved by the

Medical Society of New Jersey despite some reservations of the Council.

The ethics of execution by drugs also was discussed. There was concern expressed by the Council on refusal of admission by various state hospitals when the necessity for admission had been well established.

The Council is beginning to update the Medical Society booklet, issues in 1974, on Mental Health Services in New Jersey.

In light of the recent deaths of a number of former mental patients in boarding homes the Council brings attention to the fact that former mental patients are being warehoused in communities unable to care for them adequately.

Filed in accordance with the recommendation of the Reference Committee.

Drug and Alcohol Abuse

Richard J. Corbett, M.D., Chairman, Audubon

(Reference Committee "F")

The Committee continues to follow the mandate of the Board of Trustees to facilitate discussion and education on drug abuse issues. It has maintained a close working relationship with the Division of Narcotics and Alcohol Control of the New Jersey Department of Health and has established a working liaison this past year with the New Jersey Association of Osteopathic Physicians and Surgeons, the Committee on Impaired Physicians and the pharmaceutical industry.

The well-respected booklet "This Side Up" was distributed to the membership for placement in their waiting rooms. This booklet deals with alcohol and drug abuse in an easily communicated style. The Department of Health was of valuable help in this project.

The Committee was represented on the New Jersey Department of Education's Alcohol and Drug Abuse Steering Committee which formulated a curriculum for the education of health teachers. This program recently has begun in four areas throughout the State.

The Board of Trustees accepted the Committee's advice in reference to not advising raising the drinking age to 21 this year, until further study of the effects of the recent raise to age 19 is formulated. We will be reporting to the Board again on this issue next year.

The Committee supported the Committee on Impaired Physicians' proposal for the hiring of a full-time coordinator.

The Chairman attended the White House Conference on "Prescription Drug Abuse, Misuse and Diversion" in No-

vember 1980. At that meeting information was gathered on the national scope of the problem. The conference suggested that individual states formulate policy in regard to the symposium's major issues.

A major symposium was sponsored by the Committee and the Academy of Medicine of New Jersey, with the help of the Department of Health, and held at the Rutgers Medical School in April. The symposium's major theme was the physician's role in drug and alcohol abuse. The symposium was video-taped with the help of the Department of Health and will be made available through the Academy of Medicine of New Jersey for continuing medical education.

The Board of Trustees of the Medical Society of New Jersey this year supported the Committee's recommendation that the Medical Society write an official letter to the Governor requesting that he set up a study group to investigate prescription drug abuse, misuse and diversion in the State, with the idea of making meaningful changes in the current laws and operations of the State on these issues.

The Committee has established liaison with the Governor's Committee on Youth and has begun to gather information with respect to drug and alcohol problems within the State of New Jersey involving youth and also for evaluation of treatment facilities for this age group.

Filed in accordance with the recommendation of the Reference Committee.

Impaired Physicians

Edward T. Carden, M.D., Chairman, Moorestown

(Reference Committee "F")

The Impaired Physicians Committee is now a highly active organization with different levels of membership and affiliation and liaison with many other organizations, including the State Board of Medical Examiners.

We have processed approximately 120 chemically impaired physicians and have assisted in approximately 40 impairments that did not involve chemicals.

The most significant progress this year is the Committee's goal for funding and selecting a full-time Executive Coordinator. His role would be that of an innovator and educator across the state, who would work primarily in the field of addiction.

The Committee received approval of this from the Board

of Trustees of the Medical Society and a three-year grant in the amount of \$50,000 from the Medical Inter-Insurance Exchange of New Jersey. Present negotiations for additional funding are being proposed with Prudential, the New Jersey Hospital Association and Blue Cross and Blue Shield of New Jersey.

Filed in accordance with the recommendation of the Reference Committee.

Reference Committee noted that it was the unanimous opinion of those at the Reference Committee hearing that there is need for a fulltime executive coordinator for this Committee and that the Board of Trustees should provide for the necessary funds.

Membership Inquiry and Complaint

Joseph C. Lucci, Director, Medical and Insurance Affairs, Lawrenceville

(Reference Committee "F")

The Membership Inquiry and Complaint Committees were established to handle complaints with Medicare, Medicaid, Medical-Surgical Plan of New Jersey, and other Health Insurance Carriers. These four Committees did not meet formally, since all complaints were resolved to the satisfaction of the physicians. For Medicare, ten complaints were

received, with two pending. For Medicaid, three complaints were received. For the Medical-Surgical Plan, three complaints were received. For other Health Insurance Carriers, three complaints were received.

Filed in accordance with the recommendation of the Reference Committee.

Medicaid

Arganey L. Lucas, Jr., M.D., Chairman, Morristown

(Reference Committee "F")

MEDICAID SURVEY OF OCEAN COUNTY BY PUBLIC ADVOCATE

The Board of Trustees directed the Committee to consider whether a survey should be conducted in each county to determine the number of physicians treating/not treating Medicaid patients, and the effect on the medical care of these patients. This Committee, in reviewing the finding of the Council on Medical Services on this same topic, is in agreement that if there are any problems with the availability of physician services, the individual county medical societies should be contacted.

The Committee also considered conducting a survey, but in view of the previous survey conducted by the Committee on Medicaid, when only forty percent of the physician membership replied, a true picture of physicians treating/not treating Medicaid patients would not be represented.

The Committee recommended and the Board of Trustees approved that no survey be conducted at this time in any county for physicians treating Medicaid patients without the prior approval and agreement of the appropriate county medical society and that the county medical societies have a special committee to monitor complaints, with proper publication at the county level.

NEW JERSEY REIMBURSEMENT COMPARED TO OTHER STATES

The Committee was presented with a graph comparing New Jersey's reimbursement for a code 9000 with other states. A graph comparing the rate of inflation with the increase in physician reimbursement also was presented.

The Committee recommended and the Board of Trustees approved that the Medical Society of New Jersey take appropriate steps to introduce legislation to include a provision in the New Jersey Medicaid laws for physicians' fees to

be upgraded annually, in the same manner as nursing homes and hospitals.

MEDICAID PILOT PROJECT

A pilot project to include primary care physicians in Atlantic and Mercer Counties has been approved by both county medical societies. This is being considered because of the high cost of patients going to the emergency department of hospitals. Physicians will be reimbursed the usual and customary fee, and it is hoped that the project will be well on its way by mid 1981. If successful in these two counties it will be a model for the whole state.

PROCEDURE CODE CHANGE

The Committee stills acts as liaison with the Division on Medicaid on matters of mutual interest. One of the items reviewed this year was the proposal for the procedure code changes. A subcommittee was appointed and has been working to bring this matter to finality.

COUNTY REPRESENTATION

The Committee does not have representation from all county medical societies. In spite of all attempts, some counties have refused to send representation to the Medicaid Committee. It is felt that input is needed from all counties in order to present a unified front in an attempt at solving the enormous problems involved in the care of the underprivileged. Names of those nonparticipating counties are on record.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#2

Introduced by: **Morris County Medical Society**

Subject: **MODIFICATION OF THE MEDICAID PROGRAM**

Referred to: **Reference Committee "F"**

Whereas, Medicaid was designed to provide equitable health care for the indigent populace and has failed to do so; and

Whereas, fees for medical services provided to Medicaid recipients were originally inadequate; and

Whereas, Medicaid has totally and utterly failed to keep pace with the inflationary spiral, and in most cases now no longer covers the physical overhead of such services, let alone a reasonable fee for physicians' services; and

Whereas, many physicians in New Jersey feel that Medicaid has demeaned both physicians and health care recipients through a cumbersome bureaucracy; and

Whereas, physicians wish to recreate a personal doctor-patient relationship based on the mutual responsibility of the patient for his own health care and the doctor for the

provision of that care; and

Whereas, the physicians of New Jersey are willing to render health care for the patients of New Jersey regardless of the patient's ability to pay; now therefore be it

RESOLVED, that the Medical Society of New Jersey recommend to the Governor and the State Legislature that the state Medicaid program be modified so as to provide a usual and customary fee to physicians for services rendered. ~~and that the bureaucracy be revamped to eliminate obstacles to smooth functioning of the program to provide health care to indigent patients of New Jersey.~~

Amended by the Reference Committee by deletion of the section indicated and inserting a period after the word "rendered."

Adopted as amended by the Reference Committee.

#8

Introduced by: **Frank J. Primich, M.D., Delegate Hudson County**

Subject: **OPPOSITION TO DIAGNOSIS RELATED GROUPS**

Referred to: **Reference Committee "F"**

Whereas, S-446 was enacted into law with minimal appreciation of the problems entailed in its implementation; and

Whereas, DRGs represent a desperate unproven approach to overcoming some of the obstacles being encountered; and

Whereas, the DRG approach initially received conditional approval from MSNJ upon assurance that it was a limited experimental program; and

Whereas, proposed full implementation constituted lack of good faith on the part of the New Jersey Department of Health; and

Whereas, MSNJ (Resolution #3, 1980) declared its opposition to DRGs, and recommended a moratorium regarding further implementation; and

Whereas, legislators who had supported or tolerated the concept on the basis of similar misrepresentation have been

aroused to action; and

Whereas, support by those inefficient hospitals which believe that the program would benefit them has blunted the ability of the New Jersey Hospital Association to continue actively to lead the opposition; and

Whereas, it is the moral duty of MSNJ to strive for *high quality of health care above all else*; now therefore be it

RESOLVED, that the Medical Society of New Jersey reaffirm its opposition to the concept of diagnosis related groups; and be it further

RESOLVED, that MSNJ assume the leadership role in coordinating opposition to DRGs, and in supplying appropriate data to the Legislature.

Rejected in accordance with the recommendation of the Reference Committee. (Similar to Resolution #14, page Tr 59.)

#9

Introduced by: **Frank J. Primich, M.D., Delegate Hudson County**

Subject: **OPPOSITION TO HEALTH SYSTEMS AGENCIES**

Referred to: **Reference Committee "F"**

Whereas, Resolution #5 (1980) received the reference committee recommendation for approval; and

Whereas, said resolution had majority support in discussion of the full House of Delegates prior to its referral to the Board of Trustees for "appropriate" redrafting; and

Whereas, such procrastination has prevented any appropriate action for the past twelve months; and

Whereas, there has been further evidence of the disruptive effect of HSAs upon the delivery of quality health care; and

Whereas, these events have made the original wording of Resolution #5 extremely "appropriate"; now therefore be it

RESOLVED, that the Medical Society of New Jersey go on record as being opposed to the continuing authority of these consumer-dominated health systems agencies to mandate the degree and direction of future health care; and be it further

RESOLVED, that the Medical Society of New Jersey make known to the public its opinion, as an organization of health care providers, that there is little justification for the continued cost to the taxpayers of these politically motivated agencies.

Adopted in accordance with the recommendation of the Reference Committee.

#14

Introduced by: **Hudson County Medical Society**

Subject: **OPPOSITION TO DIAGNOSIS RELATED GROUPS (DRGs)**

Referred to: **Reference Committee "F"**

Whereas, S-446 was enacted into law with minimal appreciation of the problems entailed in its implementation; and

Whereas, the diagnosis related group approach initially received conditional approval from the Medical Society of New Jersey upon assurance that it was a limited experimental program; and

Whereas, the Medical Society of New Jersey (Resolution #3, 1980) declared its opposition to DRGs, and recommended a moratorium regarding further implementation; now therefore be it

RESOLVED, that the Medical Society of New Jersey reaffirm its opposition to the concept of diagnosis related groups; and be it further

RESOLVED, that the Medical Society of New Jersey take the leadership role in coordinating opposition to DRGs, and in supplying appropriate data to the Legislature.

Adopted in accordance with the recommendation of the Reference Committee. (Similar to Resolution #8, page Tr 58.)

#16

Introduced by: **Camden County Medical Society**

Subject: **DISCONTINUANCE OF FUNDING FOR HEALTH MAINTENANCE ORGANIZATIONS**

Referred to: **Reference Committee "F"**

Whereas, in December 1980 at the Interim Meeting of its House of Delegates, the American Medical Association reaffirmed a clear-cut position on health maintenance organizations as outlined by the Council on Medical Service's report, which states: "Approval of the concept of neutral public policy and fair market competition among all systems of health care delivery continue to be AMA policy, with the potential growth of HMOs being determined not by federal subsidy, preferential federal regulations, and federal advertising promotion, but by the number of people who prefer this mode of delivery"; and

Whereas, the Health Care Plan of New Jersey which operates in Camden County has received \$1,605,557 in grants and \$3,154,000 in loans; and

Whereas, the total amount of grants and loans for HMOs/IPAs in New Jersey as of November 14, 1980, was \$23,610,110; and

Whereas, the Congress of the United States will consider renewal of the HMO enabling legislation in the 97th Congress (*AMA News*, October 3, 1980, page 17); and

Whereas, the Reagan Administration plans to ask that the federal grant and loan subsidy program for health maintenance organizations be eradicated (*AMA News*, February 27, 1981, page 9); now therefore be it

RESOLVED, that the Medical Society of New Jersey urge the House of Delegates of the American Medical Association to recommend to the enabling committees of Congress and to the Health Care Finance Administration (HCFA) that any further grants or loans to health maintenance organizations be abolished.

Adopted in accordance with the recommendation of the Reference Committee.

#18

Introduced by: **Essex County Medical Society**

Subject: **FIVE-DIGIT PROCEDURE CODING**

Referred to: **Reference Committee "F"**

Whereas, insurance carriers process claims for medical services by entering code number(s) for the service(s) into a computer record; and

Whereas, the accuracy of claim payment is directly related to accuracy of coding; and

Whereas, various procedure-coding systems have been developed over the years, all originally based on four-digit codes; and

Whereas, more recently developed five-digit coding systems are more comprehensive and more precise, exemplified by the American Medical Association's "Current Procedural Terminology," now in its fourth edition (CPT-4), developed

with multispecialty input and continuing update; now therefore be it

RESOLVED, that the Medical Society of New Jersey be recorded as favoring five-digit procedure coding; and be it further

RESOLVED, that the Medical Society of New Jersey notify the major health insurance carriers in New Jersey, and request them to adopt ~~CPT-4 procedure coding~~ **an appropriate, nationally used five-digit procedure coding system such as the CPT-4 or the ICD-9CM coding system.**

Amended by the House as indicated above and referred to the Board of Trustees. Reference Committee recommendation had been for adoption as originally written.

#25

Introduced by: **Board of Trustees**

Subject: **HEALTH SYSTEMS AGENCIES (HSAs)**

Referred to: **Reference Committee "F"**

RESOLVED, that the Medical Society of New Jersey memorialize the AMA to continue to seek repeal of P.L. 93-641 (National Health Planning and Resources Development Act); and be it further

~~RESOLVED, that the Medical Society of New Jersey seek to modify the Health Systems Agency (HSA) system in New Jersey to maximize local decision making; and be it further~~

RESOLVED, that the Medical Society of New Jersey develop a means to promote the involvement of member physicians in health planning.

Amended by the Reference Committee by deletion of the second resolved, as indicated.

Adopted as amended by the Reference Committee.

#26

Introduced by: **Gloucester County Medical Society**

Subject: **NEW JERSEY \$2 PRESCRIPTION PROGRAM FOR THE ELDERLY**

Referred to: **Reference Committee "F"**

Whereas, the medical doctors of New Jersey, having the sincere interest of the elderly at heart; and

Whereas, many elderly persons have lost their \$2 prescription benefits because of Social Security raises combined with their other income or pensions; and

Whereas, it has become a great hardship for many of the chronically ill to pay for their drugs without the aid of the State of New Jersey in the \$2 prescription program; now therefore be it

RESOLVED, that the Medical Society of New Jersey recommend that the Governor and the State Legislature amend the

New Jersey state prescription program; and be it further

RESOLVED, that the maximum income limits for the \$2 prescription drug program be raised by the same percentage that Social Security payments are raised, and to be effective on the same dates; and be it further

RESOLVED, that a copy of this resolution be sent to the Governor of the State of New Jersey and to both Houses of the Legislature.

Adopted in accordance with the recommendation of the Reference Committee.

REFERENCE COMMITTEE "G"

Jeffrey M. Solomon, M.D., Cumberland
Chairman
Marc J. Crilly, M.D., Bergen
George T. Hare, M.D., Camden
Lawrence C. Sylvia, M.D., Monmouth
Frank A. Wolf, M.D., Warren
George L. Triebenbacher, M.D., Ocean
Alternate Member

Reports:

Board of Trustees' Items
Committee on Chronically Ill
and Aging
Council on Public Health and its
Special Committees on:
Cancer Control
Child Health
Conservation of Hearing and
Speech
Conservation of Vision
Environmental Health
Maternal and Child Care
Committee on Medical Aspects of
School Sports

Resolutions #11, #39E

Board of Trustees' Items

CESSATION OF SLUDGE DUMPING

(Reference Committee "G")

The United States Environmental Protection Agency has responded to Resolution #15 (1980 House of Delegates) indicating that it consistently has enforced the 1981 deadline against municipalities' ocean-dumping sewage sludge. Over the past two years, fifteen municipalities have been phased out of ocean dumping of sewage sludge, leaving approximately twenty remaining. Furthermore, the agency has taken the position that the remaining dumpers must comply with implementation schedules providing for phasing out their dumping by December 31, 1981, or earlier.

The New Jersey Department of Environmental Protection, however, is unable to support the complete cessation of the ocean dumping of sludge after 1981, at the cost of other serious detrimental effects on New Jersey's environment. It does firmly support the absolute ban on such dumping in the Inner New York Bight and is of the opinion that the 106-mile site is the appropriate location for this activity until environmentally sound land-based alternatives can be developed and shown to be feasible for all of New Jersey's sludge dumpers.

Filed in accordance with the recommendation of the Reference Committee.

REINSTATEMENT OF THE AMA COMMITTEE ON THE MEDICAL ASPECTS OF SPORTS

(Reference Committee "G")

A resolution from the New Jersey delegation was presented to the AMA House of Delegates urging the Board of Trustees to reinstate the Committee on the Medical Aspects of Sports.

In a report from the Board of Trustees, it was noted that the AMA Council on Scientific Affairs has considered this issue repeatedly and has continued to report that the current system of utilizing an advisory panel of physician consultants in place of the former Committee on the Medical Aspects of Sports serves the need of the AMA as well as the earlier Committee.

The House of Delegates voted against reinstatement of the Committee.

Filed in accordance with the recommendation of the Reference Committee.

CHEMICAL DUMP EXPLOSION IN ELIZABETH

(Reference Committee "G")

In his reply to the Society's request for full disclosure of the chemical dump explosion in Elizabeth (1980 House of Delegates), Governor Byrne noted that over ten federal, state and local agencies were involved in responding to the chemical control fire. For this reason, a single source, the federal Environmental Protection Agency, served as the central clearing-house for all scientific information and data. The agency will be releasing a report containing all the data taken at Chemical Control with annotations designating their significance.

Filed in accordance with the recommendation of the Reference Committee.

STATE PERINATAL DESIGNATION PLAN

(Reference Committee "G")

The Board of Trustees notified the Governor and the Commissioner of Health of its concern with the Perinatal Designation Plan developed by the New Jersey Department of Health.

The plan, as proposed, would establish a level of hospital care that is in opposition to the one recommended by the New Jersey Chapter of the American Academy of Pediatrics. Many hospitals in the state are providing excellent perinatal intensive care and the proposed changes in the current program, based on a formula developed by the Department of Health, would terminate these services in some areas.

The Board urged the Commissioner of Health to suspend the plan and to meet with representatives of the New Jersey Chapter of the American Academy of Pediatrics to resolve the attendant differences.

Filed in accordance with the recommendation of the Reference Committee.

RUBELLA SCREENING OF ALL HEALTH CARE FACILITY EMPLOYEES

(Reference Committee "G")

The Board of Trustees considered reports from the Society's Council on Public Health and Committee on Maternal

and Child Care pertaining to the regulation on Rubella (German Measles) Screening of All Health Care Facility Employees (N.J.A.C. 8:31-26.3). The regulation calls for all persons employed in clinics and/or medical practices where pregnant women are receiving care to be immunized against rubella in order to prevent damage to the unborn fetus.

Separate recommendations were presented to the Board by each group. The Committee on Maternal and Child Care recommended acceptance of the regulation, with the inclusion of physicians, volunteers, and all regularly employed

personnel among those to be screened, with vaccine offered to those persons detected as being seronegative.

The Board of Trustees was not in favor of the Committee's recommendation and voted instead to support the recommendation submitted by the Council on Public Health calling for reconsideration of the regulation by the Department of Health.

Filed in accordance with the recommendation of the Reference Committee.

Chronically Ill and Aging

David Eckstein, M.D., Chairman, Trenton

(Reference Committee "G")

The Committee on Chronically Ill and Aging has not met during the past year. The Chairman represents MSNJ on the Governor's Long-Term-Care Planning Group and on the Governor's Committee for the White House Conference on Aging.

Without mandate on referred agenda this committee is functionless. Not necessarily for the same reason, the AMA converted the Committee on Aging into a subcommittee of

the Council on Medical Service, the members being drawn from the Council.

In view of the above, the Committee on Chronically Ill and Aging is recommending to the Board of Trustees that it be disbanded and that a subcommittee on aging be formed within the membership of the Council on Medical Services.

Filed in accordance with the recommendation of the Reference Committee.

Public Health

Edward M. Coe, M.D., Chairman, Cranford

(Reference Committee "G")

A reorganization meeting of the Council on Public Health was held on January 21, 1981.

The Council on Public Health reviewed a referral by the Council on Legislation, i.e., A-1332, marriage license and rubella response testing and recommended it be opposed by MSNJ.

The Council recommended to the Board of Trustees that MSNJ request the New Jersey Department of Health to reconsider the regulation, N.J.A.C. 8:31-26.3, which states "Each employee who is assigned to areas in the facility where

he or she may have contact with patients in their first or second trimester of pregnancy shall be rubella seropositive".

A position paper received on uranium mining in Morris County was referred to the Committee on Environmental Health for investigation and consultation with the New Jersey Department of Health and New Jersey Department of Environmental Protection for report back to the Council on Public Health.

Filed in accordance with the recommendation of the Reference Committee.

Cancer Control

Benjamin F. Rush, Jr., M.D., Chairman, Newark

(Reference Committee "G")

The initial meeting of the Committee was held September 17, 1980, at which time the function and scope of the committee was considered and it then was recommended that the group would function best as a "watchdog" and liaison to observe what is occurring in the state and make recommendations to the Society for approval or disapproval of such activities. It was suggested that organizations with which the Committee should maintain a liaison would include the American Cancer Society, American College of Surgeons, Department of Preventive Medicine—New Jersey Medical School and Rutgers Medical School, the State Department of Health, the New Jersey Association of Osteopathic Physicians and Surgeons and possibly the New Jersey Dental Association.

A small subcommittee was appointed to search out appropriate individuals to contact within these various groups and the following information was collected. Cancer Control is divided among at least three organizations within the state. These are the Department of Environmental Protection, the Department of Labor and Industry (Occupational Health) and the Department of Health, with the major roles being in the Departments of Environmental Protection and Health. Coordination between these groups was exercised to some degree by the Cabinet Committee on Cancer Control, a committee appointed by of the Governor. Plans for a meeting with a state representative in the late winter were made and I.A. Mitchell, M.D. of the Governor's Committee on Cancer Control agreed to attend as did Dr. Donald B. Louria speaking for the State Division of the American Cancer Society. These plans were aborted, however, when Dr. Mitchell concluded his two years in office on the

Governor's Cabinet and his appointment was not renewed. As far as we can determine the staff of the Cabinet Committee has been dissolved and Dr. Mitchell is now departing the state. While he was encouraged to attend our meeting in any case, he found himself too preoccupied with the problems of moving to be able to find time to meet with us. Present plans are to meet with other representatives, probably one from DEP and one from Public Health in late March or early April.

This fall the chairman represented the Medical Society of New Jersey at a meeting of the Memorial Sloan-Kettering Cancer Control Program in New York. It is of interest that the M.S.K. Cancer Control Program under its federal contract, designates the five boroughs of New York and the 12 northernmost counties of New Jersey as their geographic area. Since Columbia-Presbyterian recently has been designated as a second regional cancer center, there is some confusion as to what the ultimate designation for geographic areas of the two centers will be. M.S.K. Cancer Control Program has some contact with 16 hospitals in New Jersey and Pennsylvania and a number of programs are in the planning stage, but there is no active implementation at the present time.

As of their meeting of December 21st, the Board of Trustees of the Medical Society of New Jersey approved the suggested function and scope of the Committee indicated above and as of February 25th, the Council on Public Health encouraged the Committee to continue with its plans to meet with members of the various organizations named.

Filed in accordance with the recommendation of the Reference Committee.

Child Health

Glenn P. Lambert, M.D., Chairman, Flemington

(Reference Committee "G")

The Committee met twice during this year. No recommendations to the Council on Public Health were generated. Nevertheless, a number of tasks were accomplished.

Liaison with the New Jersey State Department of Health continues with Doctor Margaret Gregory, Coordinator, Maternal and Child Health Programs. Among current topics is an effort to update and revise the "Guidelines for Hospital Perinatal Mortality Study Conferences." The Committee will be working with representatives of the Committee on Maternal and Child Care on this program.

A representative of the New Jersey State Department of Education, Mrs. Sarah Dougherty, R.N., also attended our meetings to join in discussion of proposed legislation on

school health matters. Of particular concern was the Special Education Assembly Bill 351 which will change the classification system of children with special needs, and A-346 which concerned ratios of school nurses.

Ongoing dialogue on infant car safety systems, standard immunization cards and action programs, perinatal service levels and early identification of handicapped children rounded out our activities. For the future more will be done on school health services and education and coordinating efforts with other child health organizations in promoting car restraint safety systems.

Filed in accordance with the recommendation of the Reference Committee.

Conservation of Hearing and Speech

Aris M. Sophocles, M.D., Chairman, Trenton

(Reference Committee "G")

The Committee on Conservation of Hearing and Speech met once this year to review the implications of Senate Bill 3026 as it will affect the hearing-handicapped students of our state and the future input of this Committee.

The Committee will continue to act in behalf of the Medical Society on questions pertaining to the following: (1) future developments in hearing evaluation methods; (2) implementation of a recent law requiring tests of hearing on the newborn; (3) hearing aid regulations; and (4) situations

arising in emerging paramedical groups which the representatives of the specialty of otolaryngology have been observing for some time.

The members of this committee are to be congratulated for their determination to continue their concern in the activities on these matters.

Filed in accordance with the recommendation of the Reference Committee.

Conservation of Vision

Vincent B. Pica, M.D., Chairman, Trenton

(Reference Committee "G")

The 24th Annual Eye Health Screening Program was held during the week of September 21, 1980. Ninety hospital centers participated in the program. The number of patients screened was 10,521, of whom 4,805 had a positive test finding. This year an additional 3,571 people were screened, an increase of 51 percent over the 1979 screening program. The testing included visual impairment, ophthalmoscopy, external conditions, and tonometry.

Of those screened, 471 were considered tonometry sus-

pects. The New Jersey Commission for the Blind and Visually Impaired will follow up these cases and report to the Committee.

Since its inception, this program has screened 227,723 patients. The next Eye Health Screening Program will be conducted during the week of September 21, 1981.

Filed in accordance with the recommendation of the Reference Committee.

Environmental Health

Philip J.G. Quigley, M.D., Chairman, Elizabeth

(Reference Committee "G")

The Committee has not had any formal inquiry from the Department of Environmental Protection.

The program, started last year, in which the members of the Committee were given the names and telephone numbers of the Department's staff in charge of the area(s) of interest to each Committee member, and vice versa, has been completed.

The Committee Chairperson just has received, as a referral from the Medical Society of New Jersey's Council on Public Health, the statement of the Morris County Medical Society of August 11, 1980 on uranium mining proposals in Morris County. The Chairperson already had met with two of the

persons involved in the Morris County Medical Society's investigation. At the moment, it would seem that a resolution for the Medical Society of New Jersey's Annual Meeting of 1981 may be appropriate, although legislation already has been introduced in Trenton.

Filed in accordance with the recommendation of the Reference Committee.

Concern was expressed about the inaction of the Committee regarding the referral from the Council on Public Health on the matter of uranium mining.

Maternal and Child Care

Peter A. Beaugard, M.D., Chairman, Rutherford

(Reference Committee "G")

The Committee on Maternal and Child Care met on October 29, 1980, and February 13, 1981. A summary of the actions of this Committee follows.

SEX EDUCATION IN SCHOOLS

The Board of Trustees, following the recommendation of Reference Committee "G" adopted by the 1980 House of Delegates, requested an explanatory report from this Committee regarding its communications with the State Board of Education and the Committee favoring its mandate of family life education. It was agreed that an explanation be sent to the Board of Trustees indicating that time was of the essence when the Committee communicated with the State Board of Education, and that the Committee relied on the society's record of favoring this in prior years.

N.J.A.C. 8:31-26.3 EMPLOYEE HEALTH EXAMINATIONS—RUBELLA SCREENING AND VACCINATION

The Committee agreed that rubella screening of all health care facilities' employees be accepted with the addition that all volunteers, physicians, and other personnel who work in hospitals on a regular basis be screened for rubella and shall be offered vaccination if they are seronegative and will come

into contact with females of child-bearing age. This will be recommended to the Board of Trustees for its review.

SUBCOMMITTEE ON MATERNAL MORTALITY

James P. Thompson, M.D., Chairman

This Committee reviewed 27 maternal deaths for 1979. Educational efforts this year will be directed toward improving our understanding of central nervous system hemorrhage in the pregnant patient and attempts to decrease the incident of pulmonary embolism, postcesarean section.

SUBCOMMITTEE ON NEONATAL RECORD KEEPING

Thomas R.C. Sisson, M.D., Chairman

This Committee reviewed all items that it felt would be useful in neonatal data collection by the Department of Health for the foreseeable future. It was the intent of the Committee to have the format of the Neonatal Record Log Book complement that of the Maternity Record Log Book. As of January 1, 1981, these log books were made available free of charge to all hospitals with maternity departments, through the courtesy of the Department of Health.

Filed in accordance with the recommendation of the Reference Committee.

Medical Aspects of School Sports

Christine E. Haycock, M.D., Chairman, Newark

(Reference Committee "G")

This Committee has been active in the past two years accomplishing the following functions:

(1) Efforts to establish guidelines for the pre-participation examination of the school athlete culminated with the acceptance by the Committee of the guidelines as prepared by Committee member Dr. Paul Hirsch. These guidelines have been prepared for submission to the Board of Trustees for consideration. The recommendation when it is made would be to the New Jersey Board of Education, so that they in turn could pass the guidelines to the schools as our suggestion for the pre-participation examination. We were assisted in this regard by a group of school nurses and Mr. Abner West of the New Jersey Coaches' Association.

(2) A sports medicine conference was held on April 23, 1980 which was quite successful. Lectures were given concerning aspects of the pre-participation examination of the school athlete. The meeting was attended by physicians, school nurses, and some other interested physical education

people.

(3) As a result of the success of the previous meeting, another meeting has been scheduled to be conducted May 6, 1981. This will be a more general symposia on sports medicine with emphasis on common diseases and injuries to the school athlete. This meeting will be opened to coaches, trainers, school nurses and others as well as physicians.

(4) The Committee is continuing its aims and goals of unifying and harmonizing the work of the trainers, coaches, and physicians through their respective societies in regard to sports medicine in this State.

(5) The Committee has as its goal the desire to become a central reference point for guidance, consultation, and trouble-shooting activities referable to sports medicine for the school systems, their coaches and their trainers.

Filed in accordance with the recommendation of the Reference Committee.

Resolutions

#11

Introduced by: **Morris County Medical Society**

Subject: **URANIUM MINING AND MILLING IN NEW JERSEY**

Referred to: **Reference Committee "G"**

Whereas, there are proposals for uranium mining and milling in New Jersey; and

Whereas, such mining and milling may pose a major environmental health hazard to the people in New Jersey; and

Whereas, studies so far indicate that such hazards (including cancer induction) have not been prevented despite regulation and enforcement by state and federal agencies; now therefore be it

RESOLVED, that the Medical Society of New Jersey request a moratorium on uranium mining and milling in New Jersey

until known and suspected health hazards ~~have been identified in currently active mining and milling areas; have been successfully addressed;~~ and be it further

Amended by the Reference Committee by insertion and deletion as indicated.

RESOLVED, that a copy of this resolution be sent to the Governor of the State of New Jersey and to the New Jersey State Legislature.

Adopted as amended by the Reference Committee.

#39E

Introduced by: **Daniel N. Burbank, M.D., Delegate
Essex County**

Subject: **TOXIC CHEMICAL WASTE STOCKPILE**

Referred to: **Reference Committee "G"**

Whereas, we are becoming more aware of the devastating toxicity of the byproducts derived from chemical reactions which are the inevitable consequences of manufacturing; and

Whereas, the At-Sea Incineration Corporation of Connecticut, known hereafter as the ASIC, wants to concentrate in large storage tanks these toxic wastes in the Newark Bay Area, where it would affect one of the most densely populated areas of the world; and

Whereas, the ASIC desires to truck chemical wastes from at least six (and possibly more) surrounding states to Port Newark for storage before loading ships, which will sail 100 miles out to sea; and

Whereas, this proposal would establish New Jersey as "the garbage state"; and

Whereas, this proposal would constitute a serious hazard to life and property; and

Whereas, it has become apparent to our Legislators that there is no easy way, no safe way, to detoxify these by-products without great expense; now therefore be it

~~**RESOLVED**, that the Medical Society of New Jersey work directly with the Greater Newark Bay Coalition to achieve~~

~~legislation which will keep the At-Sea Incineration Corporation and other out-of-state dumping firms out of the New Jersey area, and be it further~~

~~**RESOLVED**, that there be further investigation as to the detoxification or otherwise chemical neutralization of these wastes so that they are rendered harmless; and be it further~~

~~**RESOLVED**, that the cost of further investigation by a third party be borne by the companies involved in the propagation of the aforesaid toxic chemical wastes; and be it further~~

~~**Amended by the Reference Committee by deleting the first three resolves and substituting the following resolved:**~~

~~**RESOLVED**, that the Medical Society of New Jersey work directly with the State of New Jersey and its appropriate agencies to stop the storage and dumping at sea of toxic material; and be it further~~

RESOLVED, that the Medical Society of New Jersey send copies of this resolution to the designated officials of the Environmental Protection Agency, the National Oceanic Atmospheric Agency, the New Jersey Department of Environmental Protection, as well as to the Governor and other concerned government officials.

Adopted as amended by the Reference Committee.

REFERENCE COMMITTEE "H"

Bernard Robins, M.D., Essex

Chairman

David L. Broadnax, M.D., Bergen

Charles J. Moloney, M.D., Burlington

Abraham Oxenstein, M.D., Sussex

Blackwell Sawyer, Jr., M.D., Ocean

Frank J. Laudonio, M.D., Union

Alternate Member

Reports:

Committee on Annual Meeting

MSNJ Auxiliary Advisory Committee

Nominations for Emeritus Membership

Resolution # 35

Annual Meeting

Ralph J. Fioretti, M.D., Chairman, Rochelle Park

(Reference Committee "H")

We were, indeed, fortunate to be able to schedule the 214th Annual Meeting in the Meadowlands Hilton, Secaucus, after learning that facilities in Atlantic City would not be available. Subsequent to the 1980 Annual Meeting, it was learned that the dates of Friday, May 15 through Tuesday, May 19, 1981, were being held for the 215th Annual Meeting of MSNJ. These dates were accepted after ascertaining that there were no 1981 dates available at the facility in Atlantic City. The Atlantic City Convention Bureau has confirmed dates for 1982 and 1983 at Resorts International.

The main objection to the 1980 meeting was the lack of planned activities for the Auxiliary; a special convention event is planned for Saturday, May 16, 1981, which will include a behind-the-scenes VIP tour of the entire complex of Lincoln Center, in addition to a visit to the World Trade Center for breath-taking views and the delectable international grand buffet at the Windows of the World. Another objection was the lack of sufficient eating facilities. In addition to those in the Meadowlands Hilton, there are two excellent restaurants in the sports complex, as well as several others in the immediate area.

The Golden Merit Award Ceremony will be returned to the annual meeting, rather than holding it in the Society's Headquarters in Lawrenceville. It is scheduled for 12 noon on Saturday, May 16, 1981, in Ballrooms C and D (the same rooms in which the House of Delegates will convene at 2 p.m.).

Because the annual meeting agenda is too lengthy as it presently exists, a proposal for shortening the convention by eliminating Tuesday was approved by the Committee on Annual Meeting and the Board of Trustees.

The AMA-ERF Boutique will adjoin the Auxiliary Arts and Hobbies in the Exhibit Hall, rather than be located in the Registration Area; Informational Exhibits will be eliminated; table-top space will be reserved for presentations by the Academy of Medicine of NJ, MSNJ's Committee on Drug and Alcohol Abuse, JEMPAC, NJ Foundation for Health Care Evaluation, MSNJ Student Association and the Society for the Relief of Widows and Orphans. Scientific and Technical Exhibits and Prudential's Coffee Lounge will be housed in the Exhibit Hall, while the Message Center, to be

sponsored by the Medical Assistants, will be located in the Registration Area.

Although the AMA Auxiliary meets in a facility other than the headquarters of the AMA, MSNJ's Auxiliary specifically requested that they be allowed to meet in the same hotel as our House of Delegates. In 1980, because of space required for Auxiliary functions, it was necessary to crowd the House of Delegates into two sections of the Ballroom instead of utilizing the entire area. There are very few, if any, facilities large enough to accommodate our House in the schoolroom set-up that the Delegates seem to prefer. The solution to the overcrowding would be to reduce the size of the House of Delegates. The AMA has 276 members in its House, whereas MSNJ numbers over 400.

In addition to 17 scientific sessions, with presentations to be made by 65 outstanding speakers, there will be programs presented by the Committee on Drug and Alcohol Abuse in cooperation with the NJ State Department of Health, the Committee on Medicine and Religion and the Annual Spencer T. Snedecor Trauma Oration. All of MSNJ's scientific sections are urged to present scientific sessions annually; however, as of this writing, three sections have not submitted programs for presentation in 1981—Plastic and Reconstructive Surgery, Rheumatism, and Urology.

The Gloucester County Medical Society and the Medical Society of New Jersey will co-host the Inaugural Reception and Dinner, to be held on Sunday evening, May 17; tickets will be available—\$5 per person for the Reception; and \$40 per person for the Dinner-Dance.

The JEMPAC Breakfast is scheduled for 7 a.m., Monday, May 18; and the Wine and Cheese Reception will be held at 6 p.m., Monday evening.

The *Advance Program* was mailed to the membership in early March; and the *Official Program* will be distributed to all who register at the Convention.

RECOMMENDATIONS

1. That the annual meeting agenda be shortened as follows, beginning with the 1982 Annual Meeting:

- a. Hotel registration Friday evening
- b. Delegate registration 5-7 p.m., Fri.; 7:30-9 a.m., Sat.

- c. First session of the House 9 a.m., Saturday
- d. Adjourn the House at mid-morning on Saturday; reconvene for election session; adjourn and schedule all reference committee meetings for that afternoon and Sunday
- e. Schedule all scientific sessions for Saturday and Sunday
- f. Reference committee reports will be considered on Monday (beginning at 9 a.m.), eliminating the Tuesday session.

Items "d" and "e" amended by the Reference Committee as indicated.

Approved as amended by the Reference Committee.

- 2. That the Medical Society of New Jersey accept the 1982 and 1983 dates as offered by Resorts International, but that at the end of the 1983 Annual Meeting the Medical Society of New Jersey obtain comparative bids from other Atlantic City hotels in an effort to obtain the best arrangements and facilities available.

Approved in accordance with the recommendation of the Reference Committee.

Filed in accordance of the recommendation of the Reference Committee.

MSNJ Auxiliary Advisory

Frank R. Romano, M.D., Chairman, Dunellen

(Reference Committee "H")

The first meeting of members of the Committee with officers of the Auxiliary was held at the Lawrenceville headquarters on July 13, 1980. There were two items on the agenda:

- (1) Social programs for the ladies at the annual meeting of the Society at the Meadowlands Hilton (May 16th-19th)
- (2) How to deal with the dwindling membership of the Auxiliary.

President Grimes, after consulting with her Executive Board and various county presidents, will present programs for Auxiliary members.

The second item, a more serious problem, dealt with means of bolstering the dwindling membership of the Auxiliary. Two counties—Mercer and Morris—instituted joint billing as a means to accomplish this. It proved to be highly successful. Joint billing means placing the Auxiliary dues (currently \$16 per year—State and National) on the bill which is sent to physician members of the county societies. Dues' billing is a county function. Members of our committee voted in favor of this proposal. I later called the other members of my Committee and all agreed with the actions taken. I subsequently contacted Vincent Maressa and he pointed out that this would be a county decision and it has

the approval of the Medical Society of New Jersey.

Mrs. Wayman, Membership Chairman, then sent a letter to all county societies offering to meet with their executive boards and explain the program and assist them in implementing it. As a member of the Mercer County Medical Society Auxiliary, she is well experienced in joint billing.

At the Annual Meeting last year, the Long Range Planning Committee was mandated to reevaluate the function of the Advisory Committee in order to increase its effectiveness and activity. Doctor Bernard Robbins, a member of the Long Range Planning Committee was assigned this task. The Committee met on November 19, 1980 at State Society headquarters and President Julie Grimes and myself were invited to attend. Doctor Robbins formulated a highly commendable report. The report was discussed at length and was unanimously approved by the committee.

The Board of Trustees approved most of the recommendations and tabled others for future consideration. Since these actions appear in the minutes of the Board and are published monthly in *The Journal*, I will not repeat them here.

Filed with commendation to the Committee in accordance with the recommendation of the Reference Committee.

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1981 Annual Meeting have been received from the component societies. Conforming to the provisions of the Bylaws, Chapter I—Membership, Section 1—Composition (e), all nominees have been members in good standing of a component society and who by reason of age or infirmity have retired from the active practice of medicine; or members of this Society who have been disabled by reason of military service.

Atlantic County

Louis S. Fornasier, M.D., Somers Point; Age 71

Bergen County

Dino D. Calabrese, M.D., Fort Lee; Age 67
Albert W. Cloud, M.D., Englewood; Age 81
David J. Fant, M.D., Suffern, NY (formerly Ridgewood); Age 60
Fred J. Fechner, M.D., Hackensack; Age 80
George A. Hoffman, M.D., Hackettstown; Age 60

Bergen County

Elias Lika, M.D., HoHoKus; Age 66
Philip J. MacLaren, Tenafly; Age 70
William P. Magee, M.D., Highland Lakes; Age 67
Walter F. Modrys, M.D., Cliffside Park; Age 74
Irene D. Pindar, M.D., Teaneck; Age 78
Samuel B. Reich, M.D., Lantana, FL (formerly Hackensack); Age 79

Burlington County

James J. Hogan, M.D., Mount Holly; Age 71
Watson E. Neiman, M.D., Altamonte Springs, FL (formerly Riverton); Age 66
Alan M. Schaeffer, M.D., Delanco; Age 66
Luis E. Viteri, M.D., Mount Holly; Age 77

Camden County

Mario A. Cinquino, M.D., Longport; Age 67
A. Joseph Hughes, M.D., Haddonfield; Age 67
John S. Klinger, M.D., Haddon Heights; Age 69
Claude C. Sullivan, Jr., M.D., Surf City; Age 63

Essex County

Benjamin B. Burrill, Jr., M.D., Verona; Age 70
Edwin L. Ciccone, M.D., Berkeley Heights; Age 67
P. Gordon Dawson, M.D., Seattle, WA (formerly Newark); Age 66
William Forte, M.D., Toms River; Age 60
Marie Kaney, M.D., Morristown; Age 69
Harold Mancusi-Ungaro, M.D., North Miami Beach, FL (formerly Upper Montclair); Age 61
Arthur Solk, M.D., Newark; Age 84
John J. Torppey, M.D., Toms River; Age 68
Robert Underwood, M.D., Cranbury; Age 71

Hudson County

Irving Dershewitz, M.D., Pompano Beach, FL (formerly Jersey City); Age 70
Nathan Frank, M.D., Jersey City; Age 75
John G. Garbarini, M.D., Croton-on-Hudson, NY (formerly Jersey City); Age 69
Leo Horowitz, M.D., Jersey City; Age 64
Samuel J. Megibow, M.D., Cliffside Park; Age 69
Louis A. Monica, M.D., Jamesburg; Age 67
John R. Rossi, M.D., Bayonne; Age 70

Middlesex County

Marie Delcau, M.D., West Palm Beach, FL (formerly South River); Age 73
Bernard Friedenthal, M.D., Milltown; Age 69

Morris County

Dexter B. Blake, M.D., Basking Ridge; Age 67
Morris Dirdack, M.D., Morristown; Age 67
Janet L. Eckhardt, M.D., Morristown; Age 63
Guy Henry Laudig, M.D., Morris Plains; Age 71

Ocean County

Carmine L. Pecora, M.D., Toms River; Age 70

Passaic County

Joseph Born, M.D., Lincoln Park; Age 65
John R. Fenwick, M.D., Totowa; Age 71

Salem County

Donald A. McLean, M.D., Palm Coast, FL (formerly Salem); Age 65
William H. Miller, M.D., Woodstown; Age 67
David G. Neander, M.D., Salem; Age 64
John Zappala, M.D., Penns Grove; Age 77

Somerset County

John F. Dixon, Jr., M.D., Far Hills; Age 68
Iwan Hyszcza, M.D., Somerville; Age 66
Irving Klompus, M.D., San Francisco, CA (formerly Bound Brook); Age 70
Martin E. Tolomeo, M.D., Bound Brook; Age 69

Union County

Frank H. Brown, Jr., M.D., Roselle Park; Age 67
Arnold N. Constad, M.D., Union; Age 67
William R. Finnegan, M.D., Elizabeth; Age 67
Stuart Orton, M.D., Rahway; Age 65

Approved in accordance with the recommendation of the Reference Committee.

Supplemental Report #1

(Reference Committee "H")

The following additional nominations for election to emeritus membership have been received:

Burlington County

Watson E. Neiman, M.D., Altamonte Springs, FL (formerly Cinnaminson); Age 67

Camden County

James R. Herron, M.D., Collingswood; Age 66

Essex County

Louis D. Fouche, M.D., Metairie, LA (formerly E. Orange); Age 62
Saul Lieb, M.D., Los Angeles, CA (formerly Newark); Age 72
Martin C. Mellicker, M.D., Essex Fells; Age 62
Thomas A. Stanley, M.D., Chatham; Age 64

Salem County

Laurence P. Devlin, M.D., Woodstown; Age 72

Union County

Frank H. Brown, M.D., Fairhaven; Age 66
Carlos M. Cane, M.D., Rahway; Age 60
Arnold N. Constad, M.D., Union; Age 66
William R. Finnegan, M.D., Cranford; Age 66
Joseph R. Hrab, M.D., Elizabeth; Age 71
Samuel D. Kaplan, M.D., Elizabeth; Age 69
Stuart Orton, M.D., Rahway; Age 64
Albert I. Whitken, M.D., Florham Park; Age 71
Jack H. Wolfsie, M.D., Westfield; Age 65

Approved in accordance with the recommendation of the Reference Committee

Supplemental Report #2

The following additional nominations for election to emeritus membership have been received:

Cumberland County

Milton Fineman, M.D., Vineland; Age 64

Essex County

Irene Giedrikis, M.D., Juno Beach, FL (formerly So. Orange); Age 65

Irving Krems, M.D., New Brunswick; Age 66

Filippo DiSanto, M.D., Elizabeth; Age 57
Anthony Sordill, M.D., Cranford; Age 70

Approved in accordance with the recommendation of the Reference Committee.

Resolution

#35

Introduced by: **Union County Medical Society**

Subject: **CHANGING THE STRUCTURE OF THE ANNUAL MEETING**

Referred to: **Reference Committee "H"**

Whereas, changes in legislation, regulation, and medical socioeconomic situations are occurring with greater rapidity than in the past; and

Whereas, to strengthen the effectiveness and importance of the Medical Society of New Jersey, more frequent discussion between the officers, the Board of Trustees of the Medical Society of New Jersey and its membership has grown to be of increasing necessity; and

Whereas, the present combination of a four-day business and social weekend results in the important work of the House of Delegates being compromised in order to meet the deadlines of social activities; and

Whereas, the expense of this protracted business/social meeting at convention facilities has become prohibitive; and

Whereas, the social and educational events could be separated from the business of the meeting to the benefit of both; now therefore be it

RESOLVED, that the Annual Meeting of the Medical Society of New Jersey be scheduled in a more expeditious manner, such as that the Medical Society of New Jersey schedule three one-day business meetings per year of the House of Delegates to be held at the MSNJ headquarters, and one annual weekend (Saturday-Sunday) meeting at a convention facility for the installation of officers and associated social and educational activities which are an indispensable part of our Society; and be it further

RESOLVED, that these changes be coordinated with the Auxiliary of the Medical Society of New Jersey.

Reference Committee recommended the following Substitute Resolution #35 be adopted:

Substitute Resolution #35

Whereas, changes in legislation, regulation, and medical socioeconomic situations are occurring with greater rapidity than in the past; and

Whereas, to strengthen the effectiveness and importance of the Medical Society of New Jersey, more frequent discussion between the officers, the Board of Trustees of the Medical Society of New Jersey and its membership has grown to be of increasing necessity; and

Whereas, the present combination of a four-day business and social weekend results in the important work of the House of Delegates being compromised; now therefore be it

RESOLVED, that the Annual Meeting of the Medical Society of New Jersey be scheduled in a more expeditious manner, such as the Medical Society of New Jersey schedule one annual three-day weekend meeting at a convention facility for the installation of officers and associated social and educational activities, as well as scheduled meetings of the House of Delegates according to the suggestions of the Committee on Annual Meeting; and be it further

~~**RESOLVED**, that there be one mid-winter interval meeting of the House of Delegates for the reception of selected committee reports, appropriate resolutions, and other urgent business; and be it further~~

RESOLVED, that these changes be coordinated with the Auxiliary of the Medical Society of New Jersey.

Adopted as amended by the House by deletion of the indicated resolved.

Reference Committee "H" believes the functions of this Committee should be expanded to include referrals of certain other committee reports, so as to carry a fuller share of the responsibilities of all reference committees. The Committee recommended that the Board of Trustees consider assigning the reports of the Committee on

Medicine and Religion, the Committee on Impaired Physicians and the Committee on Publication to Reference Committee "H."

Referred to the Board of Trustees in accordance with the recommendation of the Reference Committee.

1981 House of Delegates Election

Alfred A. Alessi, M.D., Chairman

Office	Term	Nominee and County
President-Elect	1 year	Howard D. Slobodien, M.D., Middlesex
1st Vice-President	1 year	Alexander D. Kovacs, M.D., Union
2nd Vice-President	1 year	Frank Y. Watson, M.D., Essex
Trustees:		
¹ 1st District	2 years	Bernard Robins, M.D., Essex
1st District	3 years	Douglas M. Costabile, M.D., Union
1st District	3 years	William Greifinger, M.D., Essex
2nd District	3 years	John J. Crosby, Jr., M.D., Hudson
2nd District	3 years	Michael R. Ramundo, M.D., Passaic
3rd District	3 years	Frank Campo, M.D., Mercer
3rd District	3 years	Palma E. Formica, M.D., Middlesex
4th District	3 years	John P. Kengeter, M.D., Ocean
² 5th District	1 year	Harry W. Fullerton, Jr., M.D., Salem
Judicial Councilors:		
³ 1st District	3 years	Gabor Somjen, M.D., Morris Edward M. Coe, M.D., Union
4th District	3 years	Frederick W. Durham, M.D., Camden
AMA Delegates:		
1 year		Myles C. Morrison, Jr., M.D., Morris
2 years		Edward A. Schauer, M.D., Monmouth
2 years		William J. D'Elia, M.D., Monmouth
AMA Alternate Delegates:		
⁵ 2 years		William E. Ryan, M.D., Mercer Edward A. Schauer, M.D., Monmouth
2 years		Howard D. Slobodien, M.D., Middlesex
2 years		James H. Spillane, M.D., Warren
2 years		Frank Y. Watson, M.D., Essex
Delegates and Alternate Delegates to Other States		
New York:		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	F. Sterling Brown, M.D., Atlantic
Connecticut:		
Delegate	1 year	Merton L. Griswold, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation:		
5th District	3 years	Robert F. Nunn, M.D., Cape May
6th Member	3 years	Howard H. Lehr, M.D., Union
Medical Services:		
5th District	3 years	John J. Pastore, M.D., Cumberland
6th Member	3 years	Frank A. Wolf, M.D., Warren
Mental Health:		
5th District	1 year	Friedrich K. Racke, M.D., Cumberland
3rd District	3 years	Joseph J. Kline, M.D., Mercer
6th Member	3 years	Joseph P. Cillo, M.D., Union
Public Health:		
⁴ 4th District	2 years	William Pawluk, M.D., Burlington
5th District	3 years	Samuel C. Ingraham, II, M.D., Cape May
5th Member	3 years	Patrick J. McGovern, M.D., Hudson
Public Relations:		
⁷ 2nd District	3 years	Joseph W. Bitsack, M.D., Bergen
5th District	3 years	John J. Pastore, M.D., Cumberland
Standing Committees:		
Annual Meeting	3 years	Arthur C. Dietrick, M.D., Burlington
Auxiliary Advisory	3 years	J. James Pegues, M.D., Burlington
Finance and Budget	3 years	Harry M. Carnes, M.D., Camden
Medical Defense		
and Insurance	3 years	E. Arthur Kratzman, M.D., Union
Medical Education	3 years	Edwin W. Messey, M.D., Burlington
Publication	3 years	Dirck L. Brendlinger, M.D., Burlington

¹Nominated from the floor to replace Dr. Watson who was elected 2nd Vice-President.

²Nominated from the floor to fill vacancy created by resignation of Dr. Surmonte.

³Nominated from the floor.

⁴Nominated from the floor.

⁴Voting for two only.

⁷Nominated from the floor to fill vacancy.

⁷Nominated from the floor to fill vacancy.

ATTENDANCE

County	Delegates	Members	Total
Atlantic	4	4	8
Bergen	40	55	95
Burlington	12	7	19
Camden	23	13	36
Cape May	3	1	4
Cumberland	6	5	11
Essex	66	155	181
Gloucester	4	9	13
Hudson	23	40	63
Hunterdon	2	1	3
Mercer	25	14	39
Middlesex	22	27	49
Monmouth	20	24	44
Morris	20	23	43
Ocean	11	7	18
Passaic	28	51	79
Salem	3	3	6
Somerset	7	2	9
Sussex	3	1	4
Union	34	42	76
Warren	3	—	3
Fellows and Officers	21	—	21
	380	444	824
Physician Guests			66
Physician Exhibitors			2
Total Physician Registration			892
Auxiliary			220
Visitors			217
Exhibitors			163
Total Registration			1,492

Five-Year Comparative Registration Figures

Year	Physicians	Others	Total
1981	892	600	1,492
1980	866	566	1,432
1979	838	728	1,566
1978	962	678	1,640
1977	1,115	1,125	2,240

**Transactions
1981 House of Delegates
215th Annual Meeting
The Medical Society of New Jersey**

Vol. 78, No. 8, pages Tr 1 to Tr 72

00435 762



3 1378 00435 7623

